

LONG ISLAND RESPONDS TO AMERICA'S HEALTH CARE CRISIS

HEARING BEFORE THE SUBCOMMITTEE ON HUMAN SERVICES OF THE SELECT COMMITTEE ON AGING HOUSE OF REPRESENTATIVES ONE HUNDRED SECOND CONGRESS SECOND SESSION

JANUARY 14, 1992, BRENTWOOD, NY

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LONG ISLAND RESPONDS TO AMERICA'S HEALTH CARE CRISIS

TUESDAY, JANUARY 14, 1992

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HUMAN SERVICES,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m. in the Sagtikos Theatre, Suffolk County Community College, Brentwood, New York, Hon. Thomas J. Downey (chairman of the subcommittee) presiding.

Members present: Representatives Downey and McGrath.

Staff present: John Olinger, Staff Director, and Moya Benoit Thompson, Research Director.

OPENING STATEMENT OF CHAIRMAN THOMAS J. DOWNEY

Mr. DOWNEY. Good morning. The Subcommittee will come to order. It is truly gratifying to see so many of you here this morning. The purpose of today's hearing of the Subcommittee on Human Services is to hear how America's health care crisis affects you.

Congressman McGrath and I are here to listen to you, to your concerns and to your suggestions on health care reform. I'd like to thank my good friend Congressman McGrath for joining me here today and making this a truly bi-county, bipartisan hearing. Congressman McGrath is not a member of the Select Committee on Aging, but he does serve with me on the Ways and Means Committee, so we are more honored by his presence.

I would like to share with you some recent experiences which I believe highlight our problems with health care. A woman came to see me because her son had recently lost his job and thus had lost his health insurance. His wife suffered from severe health problems and was unable to have them attended to because of their lack of insurance. I spoke to officials at a local hospital and arranged to have the woman's daughter-in-law seen at a hospital clinic. That situation was resolved satisfactorily, yet, I firmly believe that family should not have had to come to their congressman in order to receive medical care. The loss of a job is a traumatic enough event without compounding it with the added insecurity of being tossed out of the health care system.

We are all familiar with the occasional news stories where a family as to go out and fund raise so that a family member can have a much needed operation or transplant. I recently was in-

volved in helping a family in that situation. I'm deeply troubled that our society forces people to go to such lengths in order to gain access to what is by all accounts the technically best health care system in the world.

I'm reminded of the old image of a barn raising. When someone's barn burned everyone in the community got together and built a new barn. Such scenes remind us all of what is good about America, the spirit of neighborliness, of self-reliance, of volunteerism. That spirit was a good way to build a barn but I seriously doubt that it's a good way to build a health care system.

The total cost of health care today is about \$750 billion, that's last year's bill. The anticipated bill for next year is \$817 billion. And we expect by the beginning of the century, the next century, that that figure could rise to \$1.8 trillion, an unimaginable and unmanageable number. The frightening thing is that those \$750 billion are not buying health care for all Americans.

Right here on Long Island the costs of our failed health care systems are clear. In Suffolk County the county's share of the Medicaid program is approximately \$117 million. In Nassau County the share of Medicaid in 1992 will be \$113 million.

I wish that I could tell you after spending all these millions of dollars that all our neighbors here on Long Island had adequate health care, but I can't. Sadly, you just have to walk down the road here to find many people who have no health care coverage whatsoever.

In a recent poll 77 percent of the respondents said they lack the resources to pay for care should they become permanently disabled from illness, old age or accident. A third of those asked indicated that they or a family member had postponed medical treatment because they thought it would cost too much. A quarter of those asked said that they or a family member had stayed with a particular job rather than change because the health care benefits there were better. Think of that, many of our neighbors are locked into jobs because of the availability of health care benefits.

It seems hard to believe that today more Americans lack health insurance than at any time since we started Medicare or Medicaid in 1965. The latest figures show that 34.7 million Americans lack any type of health insurance coverage. An increase of 1.3 million in the past year. In New York State there are 2.176 thousand people uninsured in 1990, an increase of 55,000 over 1989. That means that just over 12 percent of New Yorkers were without this vital protection.

Just this week the Children's Defense Fund issued a report which showed that about 40 percent of all children live in families not covered by employer-based health insurance. This is a 13.7 percent in the past decade. 8.4 million children have no health insurance at all. Without Medicaid there would have been over 18 million kids without any coverage.

The sharp increase in the number of uninsured people is due, in many cases, to the sharp increase in the number of folks who are unemployed. And this reveals the greatest shame of our current health system, the fact that access to health care is dependent upon whether you have a job or the type of job that you have. There is a way out of this, it is national health insurance.

I strongly support H.R. 1300, the Universal Health Care Act, introduced by our colleague Congressman Russo. Some of you may have met with Congressman Russo when he came here with me this last summer. The Universal Health Care Act establishes the Federal Government as the sole payer for health services and covers all citizens equally.

Each State would set its own health care program and budget within the plan. The bill would establish a prospective payment system for the health care providers, and that is that a provider would be paid a fixed fee for an illness or treatment. The bill would institute strict cost controls and allow health care providers to plan more effectively for the use of their resources. Patients would not have to wade through a maze of paperwork to file a claim, and there would be no co-payments.

We're at a historic point in the debate on health care. Never before have so many Americans been united in their belief that we need to change the current system. Long Islanders are in the forefront of the effort to forge a consensus on health care.

Many of you have traveled to Washington to present your point of view. But now we're here on Long Island to hear from our friends and neighbors, and I welcome your input.

The testimony of the witnesses today will be published as an official document of the Select Committee on Aging, and will provide the basis for our future efforts on national health insurance. It is with great pleasure that I welcome all of you, and also my good friend and colleague Ray McGrath. Ray.

[The prepared statement of Chairman Downey follows:]

STATEMENT OF THE HONORABLE THOMAS J. DOWNEY
CHAIRMAN, SUBCOMMITTEE ON HUMAN SERVICES

"LONG ISLAND RESPONDS TO AMERICA'S HEALTH CARE CRISIS"

January 14, 1992

Good Morning. It is truly gratifying to see so many of you here this morning. The purpose of today's hearing of the Subcommittee on Human Services is to hear from the people of Long Island about the way America's health care crisis affects them. Congressman McGrath and I are here to listen to you, to find out your concerns, and to get your suggestions on the ways to address health care reform. First, I would like to thank my good friend, Congressman McGrath for joining me today and making this a truly bi-county, bipartisan hearing. Congressman McGrath is not a member of the Select Committee on Aging, but he does serve with me on the Ways and Means Committee, so we are all the more honored with his presence.

I would like to share with you some recent experiences which I believe highlight our problems with health care. A woman came to my office because her son had recently lost his job, and thus had lost his health insurance. His wife suffered from severe health problems and was unable to have them attended to because of their lack of insurance. I spoke to officials at a local hospital and arranged to have the woman's daughter-in-law seen at a hospital clinic. That situation was resolved satisfactorily, yet I firmly believe that that family should not have to come to their Congressman in order to receive medical care. The loss of a job is a traumatic enough event without compounding it with the added insecurity of being tossed outside the health care system.

We are all familiar with the occasional news story where a family has to go out and fund raise so that a family member can have a much needed operation or transplant. I recently was involved in helping a family in that situation. I am deeply troubled that our society forces people to go to such lengths in order to gain access to what is, by all accounts, the technically best health care system in the world.

You know, I am reminded of the old image of a barn raising. When someone's barn burned, everyone in the community got together and built a new barn. Such scenes remind us of all that is good about America: the spirit of neighborliness, of self-reliance, and of voluntarism. That spirit was a good way to build a barn, but I seriously doubt that it's a good way to build a health care system.

I can briefly provide you with some figures on health care. The total cost of health care today is about \$750 billion. By the turn of the century, that figure could rise to \$1.8 trillion, an unimaginable and unmanageable number. The frightening thing is that those \$750 billion are not buying health care for all Americans.

Right here on Long Island, the costs of our failed health care system are clear. In Suffolk County, total Federal, state and local expenditures for Medicaid were \$292,717,651 in 1987. This year, they are projected to be \$631,103,168, and increase of \$338,385,517 or 115.6% in five years. The county's share of this is approximately \$117,385,000. For Nassau County, the comparable figures are \$295,882,425 in 1987 and 590,593,000 projected for this year, for a change of \$294,710,575, or 111.9%. Nassau County government's share of this figure in 1992 will be \$113,256,722. I wish I could tell you that after spending all these millions of dollars all of our neighbors here on Long Island had adequate health care, but they don't. Sadly, you just have to walk down the road here to find many people who have no health coverage whatsoever.

Polls show that most of us are satisfied with the quality of the medical care we receive, but shockingly, in a recent poll, 77% of the respondents said they lacked the resources to pay for care should they become permanently disabled from illness, old age, or accident. A third of those who were asked indicated that they, or a family member, had postponed medical treatment because they thought it would cost too much. A quarter of those asked said that they or a family member had stayed with a particular job rather than change because the health care benefits were better. Think of that: many of our neighbors are locked into jobs because of the availability of health benefits.

It seems hard to believe that today more Americans lack health insurance than at any time since we started Medicare and Medicaid in 1965. The latest figures show that 34.7 million Americans lack any type of health insurance coverage, an increase of 1.3 million in the past year. In New York State, 2,176,000 people were uninsured in 1990, an increase of 55,000 over 1989. That means that just over 12% of New Yorkers were without this vital protection. The sharp increase in the number of uninsured people is due in many cases to the sharp increase in the number of unemployed. This reveals the greatest shame of our current health care system - the fact that access to health care is dependent on whether you have a job and the type of job you have.

Even when people who lack health insurance receive care, there is evidence that suggests that it might not be up to the same standard that insured people receive. A study published in the Journal of the American Medical Association a year ago suggested that uninsured individuals are less likely to be given routine diagnostic tests, that they are less likely to receive critical surgical procedures, and are more likely to die during their stay in the hospital. Now there could be a number of reasons for the higher mortality, but the study does point conclusively to the fact that to be without health insurance is a perilous state to be in.

There is a way out of this mess and I believe it is national health care. I strongly support H.R. 1300, the Universal Health Care Act of 1991, introduced by my good friend from Illinois, Marty Russo. Some of you may have met Congressman Russo when he came with here with me this past summer. The Universal Health Care Act establishes the Federal government as the sole payer for health services and would cover all citizens equally. Each state would set its own health program and budget within the plan. The bill would establish a prospective payment system for health care providers, that is the provider would be paid a fixed fee for an illness or treatment. The bill would institute strict cost controls and allow health care providers to plan more effectively for the use of their resources. The patient would not have to wade through a maze of paperwork to file a claim. There would be no copayments required.

I believe that we are at a historic point in the debate on health care. Never before have so many Americans been united in their belief that we need to change the system. I am happy to say that many Long Islanders have been active in the effort to forge a consensus on health care. Many of you have traveled to Washington to present your point of view and that is good. But today, we are here, on Long Island, to hear from our friends and neighbors. I welcome your input. The testimony of the witnesses today will be published as an official Select Committee on Aging document and will provide the basis of my future effort for national health care reform.

STATEMENT OF REPRESENTATIVE RAYMOND J. McGRATH

Mr. McGRATH. Thank you very much, Tom, and let me welcome all of you who have come in such lousy weather to participate with us in listening to those invited guests regarding what I consider to be perhaps the number one issue confronting the Congress of the United States at this particular point in time. Many of you are ahead of us in pointing out to us the urgency of this particular issue.

I am a member of the Ways and Means Committee, as Tom is, and I am the only member of the Health Subcommittee from New York State. And in that capacity I've had the opportunity to travel around the State, listen to people on Long Island, not only hospital officials, not only doctors and other providers, but patients and beneficiaries like yourself and myself. As a matter of fact, I'm just getting over a little bit of the flu and I feel I could use some health care myself today.

But among all of the people that I have been with and talked to about health care there seems to be at least one bottom line, and that is the system that we have today has long since been outdated and the system we have needs to be improved drastically. That is the consensus of the providers, that's the consensus of the hospital officials that I talked to, and certainly Tom has enumerated the problems with being a beneficiary of that particular system.

And as we go along now and try to find a system that would better serve our needs, I think we have to keep a few things in mind. One is that it is a shame, it's shameful that there are at least 40 million of our 250 million residents in this country who do not have any health insurance at all and probably another 10 million who are underinsured.

Two, that the system that we have today just costs too darn much and something needs to be done in order to not roll back, I don't think it's possible to roll back the costs that we've incurred over the years, but at least be able to control the growth.

Over the last 10 years while the rest of the economy was growing at perhaps a 1 or 2 percent rate and inflation was growing at a 4 percent rate, inflation in the health care delivery system was growing at a 14 percent rate. So that when we spent 665 billions of our dollars in 1990 for health care and 700 in excess of 700 billions of dollars last year for our health care, perhaps over \$800 billion in this year estimated for our health care you can see that the more that we spend on this as a percentage of what we spend on everything, our gross national product, we have less to spend on other things of great need also. So it is incumbent upon us in any plan that we devise to control the costs to the best of our ability.

And last, and perhaps in my opinion most important, Tom alluded to it in his remarks, in spite of all of the shortcomings of our system, our system still provides the best level of quality care of all of the systems that are on Earth today. And what ever we do, in my estimation, it is incumbent upon us to preserve that freedom of choice, preserve the quality of care, and preserve the kind of care that we have come to understand and enjoy here in this country.

Understand that we already have in a lot of cases a national health insurance program in this country. We have veterans care,

we have Medicare, we have Medicaid. We also have, as Tom so aptly pointed out, an employer-based system which in some cases works and in other cases does not depending upon whether your employer provides insurance for you or whether you have a job.

The bottom line is that we should as a Nation be able to provide access not only to care but to insurance for all of our constituencies. And I look forward, frankly, to the observations of the people we've invited here today to testify as to the needs of the health care on Long Island.

So, Tom, thanks a lot for having me and let's get on with the show.

[The prepared statement of Representative McGrath follows:]

STATEMENT BY HON. RAYMOND J. MCGRATH (R-VALLEY STREAM)

JANUARY 14, 1992

HOUSE SELECT COMMITTEE ON AGING

SUBCOMMITTEE ON HUMAN SERVICES

CONGRESSIONAL HEARING

"LONG ISLAND RESPONDS TO AMERICA'S HEALTH CARE CRISIS"

I am pleased to be joined here this morning by Congressman Tom Downey, my colleague on the House Ways and Means Committee. Together we will hear from our invited witnesses about America's current health care crisis.

Our current health care system requires great improvement. I have talked about health care reform with many groups - practitioners and other health professionals, industry and association leaders, Governors and state health officials, state legislative leaders, consumer organizations, and many others. All agree on one fundamental objective - health care reform must include access. Everyone should be able to obtain necessary health care. As we consider how to approach this goal, we must strive to remove financial barriers to necessary health care.

Americans, as a society, spent \$665 billion or 12 percent of gross national product on health care in 1990. Without appropriate action the problem is likely to get worse in two basic ways: first, under pressures of sharply rising health costs, both private and governmental payors will seek to restrain their costs by eliminating their contributions to cross-subsidies which ultimately provide care for the uninsured; and, second, insurers will attempt to avoid the network of insuring risky and

unprofitable businesses and individuals. As a result, more people will become uninsured and the problem of their access to care will be exacerbated.

The political issues in the health care debate revolve around the fact that health care is a \$700 billion industry which faces two competing problems; namely, the need to reduce health care costs and the need to expand access to health care.

On the political horizon, there are three major structural reform ideas: tax-based, government-run national health insurance, employer mandates (play or pay), and replacing the tax advantages for employer-sponsored insurance with individual tax credits. There are several reform proposals that would take a more incremental approach to reforming health care, including malpractice reform, insurance reform, various cost containment proposals like managed care and prevention strategies.

Health care should be available to all Americans, regardless of economic circumstances. Health care reform is too important for us to rush ahead with ill-thought-out schemes that have not been fully evaluated. I believe that Congress must move ahead with generally acceptable changes that can bring Americans immediate relief while continuing its evaluation of comprehensive reforms.

I look forward to the testimony of our witnesses this morning. Health care reform is complex and difficult and I need your help in finding the best way to ensure we maintain a quality health care system while expanding access to necessary care.

Mr. DOWNEY. Thank you, Ray. Let me also say that we'll be hearing from a variety of witnesses, and it is inevitable in a forum such as this, that somebody may feel the sudden need to testify or bear witness personally. We are happy to take your written testimony up to 2 weeks after this hearing is closed.

So if there is something that you really want to say, you can either grab Ray or me after the hearing or submit it to the subcommittee and we will add it as part of the hearing record. But today we are just going to listen to, publicly anyway, the witnesses that we've scheduled.

The first panel consists of a gentleman from Bay Shore, public witnesses, Artie Dromerhauser, Regina Block and James Leotta. If those three folks will approach the witness table. Artie, why don't you begin.

PANEL ONE, CONSISTING OF ARTHUR F. DROMERHAUSER, BAY SHORE, NY; REGINA BLOCK, ON BEHALF OF HER MOTHER, BARBARA DALLA CHIARA, SEAFORD, NY; AND JAMES LEOTTA, SENIOR PARTNER, PARADIGM DESIGN SYSTEMS, INC., PORT JEFFERSON, NY

STATEMENT OF ARTHUR F. DROMERHAUSER

Mr. DROMERHAUSER. Thank you, Congressman Downey, for inviting me here to share my story as difficult as it will be to tell. My name is Artie Dromerhauser and I'm a life long resident of Bay Shore. My wife Delores and I have 10 children, one who's deceased. Through the course of raising children you have the normal bumps and bruises and visiting the emergency room and the doctors, et cetera, and certainly in my family we're no different.

However, my children have had a few more problems than the bumps and bruises. Putting aside the normal operations of tonsils and appendicitis, three of my children have had eye surgery, two of them twice, one of them had major eye surgery to remove a tumor, another son had microsurgery on his eye to repair damage from an auto accident.

Five years ago one of my daughters had extensive surgery where surgeons were forced to remove her appendix, colon, parts of her lower intestine and her rectum. Fortunately, her illness is in remission at the present time. However, all these illnesses and injuries pale in comparison to those of my oldest son.

My oldest boy Artie is now 29. When he graduated from Bay Shore High School he was on his way to fulfilling every parent's dream of having their children go on to college and becoming a success in life. My son was a really good academic student and was blessed with even better athletic ability. He was awarded a baseball scholarship to Providence College. He went off to college in the fall of 1980.

During his senior year Artie had started suffering from an illness called colitis. Then during his fall semester at college he almost developed into ulcerative colitis which left him hospitalized and forced his withdrawal from Providence. He came back home, worked part time, took his medication, and attempted to go back to college in the fall of '81. He went back to school and, unfortunately, was immediately hospitalized again and forced to withdraw.

During the spring of 1982 he progressively got worse and was in and out of the hospital. In July of 1982 he almost lost his life. He was diagnosed as having interstitial nephritis, which is acute renal failure. He had lost 91 pounds, from 210 to 119. His kidneys shut down. One was completely gone and the other was functioning at one-third of its capacity.

By the way, as an aside, this is in litigation at the moment. As of this moment, almost 9 years later, my son is still waiting for his case to come to trial, 9 years. But this is another story for another day.

I know there are no books on parenting 101, but there are certain expectations in situations that a couple may anticipate in preparing for and raising a family. But believe me, believe me, nothing can prepare you for a death or catastrophic illness of a child.

As noted earlier, one of my children is deceased. My wife and I suffered the worst tragedy when we lost our daughter Debbie in the hospital emergency room. Then, to have two of your children suffer from major illnesses, one of a catastrophic illness, is very difficult to endure. But you do what you have to do. Not only to help the children that are sick but also to be as normal parents as possible to the other children. They all need the love, care, interest and attention that only parents can provide.

Trust me when I say that is not an easy task when you leave a hospital crying and upset, drive home, and then have to make a concerted effort to shift your emotions so that when you enter the home you are smiling to the children who greet you who are craving for and deserving of your attention. You mask your feelings, smiling on the outside while a perpetual heartache is going on inside. Compounding all the feelings you have is really like an emotional roller coaster, are the resulting financial problems that have absolutely devastated me and my family.

I guess one could say that I am fortunate in one aspect that I've always been employed and have had insurance coverage from my employers. However, all policies have deductibles and, of course, limits. Add to the equation that physicians, labs, pharmacies, et cetera, all want their money up front, and one can see that a family can get into debt very quickly.

One of the things that we did was to pay the medical expenses promptly for fear of discontinuance of care. We did this at the expense of other bills. Obviously a family does not budget the cost of catastrophic illness into their everyday living expenses. Whether you agree or not with what my wife and I did, the fact is all our other obligations began to slip. The credit cards, the utilities, the mortgage all started to be paid late.

We used up our limit on the credit cards by borrowing the allowable cash. We then applied for more credit cards doing the same. We were forced to remortgage our house, not once, not twice, but three times in 7 years. By the way, my college degree is in accounting. I have worked with numbers all my life. I taught accounting. I knew what we were doing was fiscally irresponsible, but you think with your heart and not your head when your children are sick.

During this time my son got married and went off my coverage, but he could not pick up coverage himself. Even though he was employed and medical coverage was provided, pre-existing medical

conditions were not covered. So my son and his wife had to do whatever they could. One of the consequences was that my son and his wife had to move because they could not afford to live on Long Island. Once again, another story for another day.

My son is very independent, very strong, and he has tried to make it on his own. I feel so bad for him and his wife. They have never had a chance to lead a normal life because of the dialysis he has been on, he has been on dialysis for over 5½ years, and the unbelievable health care costs.

You never recover from the costs. The accumulation of bills is like an avalanche, it just snowballs and snowballs. You wind up borrowing from Peter to pay Paul. Eventually you get to the point where your credit runs out, you've maximized your borrowing potential, you work as many jobs as possible, and you still wind up needing money and reaching a point where you just don't know what to do.

Personally I have lost my credibility as a reliable borrower. In addition, my son right after getting married had to go on dialysis. Therefore, he had to apply for disability in order to maintain some form of income stream and be eligible for what benefits were available.

I do want to enter this for the record, that the government has helped to a degree with the disability payments and a good percentage of his dialysis costs and medical expenses. However, the costs are so astronomical that 80 percent coverage still leaves a tremendous balance.

What also hurt is that my son began to lose his dignity and self worth. Here was a young man who was on his way to becoming a big success in life now forced not to work, forced not to work. Even on dialysis he could have worked a couple of days, but he couldn't because he would have lost his eligibility for the disability. His self worth eroded as a man. All these factors were added the illness and one can readily see how difficult it becomes for an individual and the family.

While I'm talking about the government there is another point that I think bears mentioning. The Internal Revenue Service also has penalized families that suffer extreme medical costs by continually increasing the percentage of adjusted gross income as a deductible for medical expenses.

Why? Doesn't the government understand that these families are suffering enough and whatever relief these families could get from taxes is extremely important? But no, the IRS just keeps raising the percentage. It's totally unfair. But it is just another example of mistreatment of people with high health care expenses.

To conclude my statement, I have to swallow, this is very difficult to do, what little pride I have left and mention what the community of Bay Shore-Brightwaters did for me and my family this summer. As I mentioned earlier, my family had exhausted all avenues of borrowing, and my son, the dialysis wasn't working anymore, had to have a kidney transplant.

We were facing all unknown costs for the transplant, they were just staggering, we had nothing to go to. And, in addition, my daughter, who just turned 18, became a medical patient because she donated her kidney to keep her brother alive. My son had been

on the national cadaver list for over a year and a half but there was no donor, there was no match.

His window of opportunity to have the transplant was closing, so the surgeons had to look to the family for a match. All of us were tested. My 18 year old daughter was a 100 percent match. The surgeons initially didn't want to take my daughter's kidney because of her age but they reconsidered because the kidney was such a perfect match and my son's condition was deteriorating.

I've attached, this is for the written record, a copy of a letter that was sent to certain community residents by a committee that was organized to help offset the financial burden. It was a bitter-sweet experience. I felt totally embarrassed, as did my son. I have always earned my way. My son didn't want to be a charity case.

However, after much discussion with the community organizers who kept coming to us saying they want to help, they want to help, we agreed to the fundraiser. As of this moment \$132,100 has been raised towards the goal. And the reasons where the dollars come are explained in the letter. The nice part of the fundraiser besides the money was the unbelievable response, some 560 people donated.

By the way, a committee is set up and controls the disbursement of funds to pay the bills. I don't want anybody to think that a check was handed to me for that amount. But this fundraiser has humbled my family.

In addition, I have trouble rationalizing why a fundraiser is necessary to pay off medical expenses. What about all the families that are in the same position as myself but do not have friends in a community that will do for them what has been done for me and my family. I have suffered immensely over the past 10 years with my son's illness but I still consider myself blessed and extremely fortunate.

I still have outstanding bills to pay from when I borrowed, and my credit rating is shot, but as I mentioned earlier I consider myself fortunate. My son is progressing nicely since his transplant. In fact, one of the things that's difficult to do when you're on dialysis is to have children. Well miracles do exist and there is someone upstairs because he and his wife have had two children in addition to one they had earlier, so they have three children. So we are very, very fortunate. My daughter who donated the kidney went off to college and is doing fine. I live in a great community and am extremely lucky to have the friends that I have.

The whole experience is something I would never, ever wish on anyone. However, I read this statement to you while continuing to feel very embarrassed and humbled, but I do this because I feel with all my might that this story has to be told because I'm just one of so many throughout the country. So many people are suffering with much more additional pain than just what an illness or disease inflicts. Congress has the power to change the system.

And I have to add this, that Congressman Downey, and not because he's sitting here, but this comes from the heart, was just such a great help. He had heard about what was going on and had some people on the committee. But more importantly, he took the time to travel on a late Sunday afternoon, unannounced, not with photographers, not with the press corps, by himself, to go visit my

son and daughter all the way up at Stony Brook just before he was flying back. And I think that just tells you something about the man.

Congress has the power to change the system. It needs to be done now. The sad part is that no one can really understand, whether it be you sitting in the audience, or Members of Congress, can understand the severity, the hopelessness, the frustration, the despair, the humility, and the tremendous pain unless you live through horrifying experience.

I pray with all my heart that everyone reading this or listening to me will not have to go through a situation like this. Most of all I pray that those who have the capacity and ability to initiate national health care reform do so immediately. So many people are hurting and need desperately the assistance that Members of Congress can provide.

Health care reform must be a top priority issue. We must learn to cut costs. We must enable the tens of millions without medical insurance to access the system, and we must offer relief to the families such as mine that have faced financial ruin and/or bankruptcy. National health care reform must take place now.

Thank you for the time.

[The prepared statement of Mr. Dromerhauser follows:]

January 6, 1992

House Select Committee on Aging's Subcommittee on Human Services,

My name is Artie Dromerhauser and I am a life long resident of Bay Shore. My wife Delores and I have 10 children (one deceased) ranging in age from 15 years of age to 29. Through the course of raising our children our family has encountered the usual amount of bumps, bruises and minor illnesses. In addition, since most of my children have been involved in athletics they have had suffered more serious injuries; broken bone in neck, broken legs, broken elbow, broken wrist, dislocated arms, concussions, etc. However, these injuries are not out of the ordinary and I consider them fairly normal.

However, my children have had more than their share of operations. Putting aside the normal operations of tonsils and appendicitis, my children have had numerous other operations. Three of my children have had eye surgery (two of them twice) on both eyes to correct abnormalities. One other daughter had major eye surgery to remove a tumor. Another son had microsurgery on his eye to repair damage that required 42 stitches.

Five years ago another daughter had extensive surgery where surgeons were forced to remove her appendix, colon, parts of her lower intestine and her rectum. Fortunately, her illness is in remission at the present time. However, all these illnesses and injuries pale in comparison to an illness that my oldest son developed.

My oldest boy Artie is now 29. When he graduated from Bay Shore High School in 1980 he was on his way to fulfilling every parents dream of having their children go on to college and becoming a success in life. My son was a real good academic student and was blessed with even better athletic ability. He was awarded a baseball scholarship to Providence College and went off to college in the fall of 1980. During his senior year at Bay Shore High Artie started suffering from an illness called colitis. Then during the fall semester at college, Artie's

budget the cost of catastrophic illness into their everyday living expenses. Whether you agree or not with what my wife and I did, the fact is all our other obligations began to slip. The credit cards, the utilities, the mortgage all started to be paid late. We used up our limit on the credit cards by borrowing the allowable cash. We then applied for more credit cards, doing the same. We were forced to remortgage our house, not once, not twice, but 3 times in 7 years. By the way, my college degree is in Accounting. I have worked with numbers all my life. I taught Accounting. I knew what we were doing was fiscally irresponsible, but you think with your heart and not your head when your children are sick.

During this time my son got married and went off my coverage, but he could not pick up coverage himself. When you get employed and medical coverage is provided, pre-existing medical conditions will not be covered. So my son and his wife had to do whatever they could. One of the consequences is that my son and his wife had to move because they could not afford to live on Long Island. Once again another story for another day. My son is very independent and has tried to make it on his own. I feel so bad for him and his wife. They have never had a chance to lead a normal life because of the dialysis (he has been on dialysis for over 5 years) and unbelievable health care costs.

You never recover from the costs. The accumulation of bills is like an avalanche. It just snowballs and snowballs. You wind up borrowing from Peter to pay Paul. Eventually you get to the point where your credit runs out, you've maximized your borrowing potential, you work as many jobs as possible and you wind up still needing money and reaching a point where you just don't know what to do. Personally I have lost my creditability as a reliable borrower. In addition, my son right after getting married had to go on dialysis. Therefore he had to apply for disability in order to maintain some form of income stream and be eligible for what benefits were available. I do want to enter for the record that the government has helped to some degree, with the disability payments and a good percentage of his dialysis costs and medical expenses. However, the costs are so astronomical that 80% coverage still leaves a tremendous balance. What also hurt is that my son began to lose his dignity and self worth. Here was a young man, who was on his way to becoming a big success in life, now forced not to work (even on dialysis he could have worked on the days he didn't have dialysis) because he would lose his disability. His self worth eroded as a man. All these factors were added to the illness and one can readily see how difficult it becomes for an individual.

While I'm talking about the government there is another point that I think bears mentioning. The Internal Revenue Service also has penalized families that suffer extreme medical costs by continually increasing the percentage of adjusted gross income as the deductible for medical expenses. Why? Doesn't the government understand that these families are suffering enough and whatever relief these families could get from taxes is extremely important. But no, the IRS just keeps raising the percentage. That is totally unfair. But, it is just another example of the mistreatment of people with high health care expenses.

To conclude my statement, I have to swallow what little pride I have left and mention what the community of Bay Shore Brightwaters did for me and my family this summer. As I mentioned earlier my family had exhausted all avenues of borrowing and we were facing unknown costs for my son's kidney transplant. In addition, my daughter Diane became a medical patient because she donated her kidney to keep her brother alive. My son had been on the national cadaver list for a year and a half, but there was no donor. His window of opportunity to have the transplant was closing, so the surgeons had to look to the family for a match. My 18 year old daughter was a 100% match. The surgeons initially didn't want to take my daughter's kidney because of her age, but they reconsidered because the kidney was such a perfect match and my son's condition was deteriorating.

I have attached a copy of the letter that was sent to certain community residents by a committee that was organized to help offset the financial burden. It was a bitter sweet experience. I felt embarrassed, as did my son. I have always earned my way. My son didn't want to be a charity case. However, after much discussion with the community organizers, we agreed to the fundraiser. As of this moment \$132,100 has been raised towards the goal of \$150,000. The reasons for the fundraiser are explained in the letter. The nice part of the fundraiser, besides the money, was the unbelievable response. Some 560 people donated. By the way, a committee controls the disbursement of funds to pay the bills. I don't want to give the impression that a check for \$132,000 was handed to me. This fundraiser has humbled my family. In addition, I have trouble rationalizing why a fundraiser is necessary to pay off medical expenses. What about all the families that are in the same position as myself, but do not have friends and a community that will do for them what has been for me and my family. I have suffered immensely over the past 10 years, but I still consider myself blessed and fortunate.

I still have outstanding bills to pay from when I borrowed and my credit rating is shot, but as I mentioned earlier I consider myself fortunate. My son is progressing nicely since his transplant. My daughter, who donated her kidney, is coming along superbly. I live in a great community and am extremely lucky to have the friends that I have.

The whole experience is something I would never ever wish on anyone. However, I write this statement and will sit before a panel and testify while continuing to feel embarrassed and humbled because I feel with all my might that this story has to be told. So many people are suffering with much more additional pain than just what an illness and or disease inflicts. Congress has the power to change the system. It needs to be done now. The sad part is that no one can understand the severity, the hopelessness, the frustration, the despair, the humility and the tremendous pain unless they live through this horrifying experience. I pray with all my heart that everyone reading this or listening to me will not have to go through a situation like my family and I have had to endure. Most of all, I pray that those who have the capacity and ability to initiate national health care reform, do so immediately. So many people are hurting and need desperately the assistance that members of Congress can provide. Health care reform must be a top priority issue. We must learn to cut costs, we must enable the tens of millions without medical insurance to access the system and we must offer relief to the families (such as mine) that have faced financial ruin and/or bankruptcy. National health care reform must take place now.

DROMERHAUSER FAMILY FUND

P.O. BOX 5174

BAY SHORE, NEW YORK 11706

June 24, 1991

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 Sidney Siben
 Gary Smith
 C.J. Stickney
 Chet Striplin

Dear Friend:

It is time for the people of Bay Shore to help a family which has never refused to help its community. Artie and Delores Dromerhauser and their 10 children have been members of the Bay Shore community for many years. Most of us know them from their long term involvement in Little League, St. Patrick's Parish, the Bay Shore Athletics Sponsors, C.Y.O., and the many other facets of community life in which they participate and belong.

As you may know, Artie Sr. is employed by Southside Hospital as Director of Development, and Delores spends most of her time caring for the needs of their 10 children.

The Dromerhausers, however, differ from most of us in one unusual and unfortunate way. Nine years ago, while attending college on a baseball scholarship, Artie Jr., then 19, was stricken with interstitial nephritis, a severe kidney disorder. For the last six years, Artie Jr. has required dialysis to treat the disorder. Unfortunately, over time the effects of treatment have diminished to the point where a kidney transplant is necessary to save his life. Doctors predict he will not survive without the operation.

Two years ago the entire family over the age of 18 was tested, but none was found to be compatible. (Artie has been on a kidney recipient list for well over a year, but a compatible tissue has not been found.) This year, finally old enough, his sister, Diane, was tested and found to be a perfect match.

Realizing that she is the only hope for her brother's survival, and fully knowing that living with one kidney places her own life in jeopardy, Diane, without second thoughts, courageously agreed to donate one of her kidneys and save the life of her brother. The operation is to be performed in July.

This situation has placed enormous emotional and financial strain on the family. Expenses incurred by Artie Sr., not reimbursable by insurance, have amounted to over \$48,000 for doctors' fees, hospital charges, prescriptions and related expenses. Artie Jr., who is not insurable, has expended \$47,250 for prescriptions, dialysis treatment, tests and related expenses. Almost \$22,000 remains unpaid at this time.

The projected cost of the operation is expected to be \$80,000. An unknown amount will be reimbursed through Federal Catastrophic Insurance. In addition, 20% of all post-operative prescriptions must be paid during the first year (projected at \$1000 per month). It is also known that Artie Jr.'s current medication has caused deterioration of both hips and knees, and ultimately both hips will require replacement. The cost of these operations is unknown at this time. Thereafter, the family must absorb 100% of expenses related to prescriptions which will be required for the remainder of his life. Additionally, the family must pay 20% of all post-operative "out of hospital" medical expenses.

(Over)

We are all aware of the unique contribution Artie has made to the children and families of our community. He is a past trustee of St. Patrick's Church and former deputy chairman of the Restoration project which raised \$1.4 million dollars. He is the treasurer of the Bay Shore Athletic Sponsors and has helped them raise \$103,000 over the last 3 years. He is the former president of the C. Y. O. where he served for seven years and former board member of the Bay Shore Little League.

Artie has also been a member of the YMCA Steering Committee for the last four years and raised in excess of \$100,000 for the new "Y". He also is a member of the Board of Directors of the Long Island Arthritis Foundation and the Suffolk Lighthouse for the Blind.

Artie's commitment to the community is also reflected in his membership in the Bay Shore Lions Club. Each year he coordinates their annual golf outing and celebrity basketball game with the New York Jets. Artie also has chaired the last three annual Good Deed Receptions which have raised in excess of \$50,000 for children involved in Scouting. Clearly, few have given so much to families and children of this community.

It is time for all of us to help a family which has never refused to help its community. They have incurred a catastrophic illness which was unforeseen and unpreventable. They have been burdened with financial responsibility that few of us if any could manage. They have done everything imaginable to save the life of their child and absorb the financial liability. They have borrowed every dollar of equity in their home. They have exhausted all other sources of loans and credit available to them. They no longer have the resources required to meet the financial obligations of this catastrophic illness.

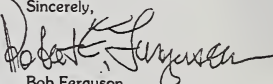
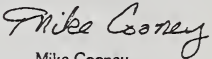
They need your help!!! They deserve your help!!!

For those whose lives have been touched by the endless work and generosity of the family, the time has come to get involved. We urge you to join those of us who have a commitment to the Dromerhauser family.

Our goal is to raise \$150,000. A goal of this magnitude requires serious considerations of unusual support levels. Please be as generous as possible!!

Enclosed is a response card. Please complete it and send it with your donation today. We thank you for your anticipated support.

HELP US PROVIDE THE GIFT OF LIFE!!

Sincerely,

 Bob Ferguson

 Mike Cooney

Athlete's Thoughts Transplanted

Bay Shore girl puts brother above all else, will donate kidney

By A.J. Benza
STAFF WRITER

At a time when most high school girls are deciding on colleges, attending their senior prom, looking forward to graduation and a summer filled with parties, Bay Shore's Diane Dromerhauser is getting ready to save her brother's life.

Several days after graduation, Dromerhauser will donate one of her kidneys to her older brother, Artie, who is severely ill with a kidney disease called interstitial nephritis. Artie, 28, was first stricken with the disease nine years ago while attending Providence College on a baseball scholarship and has been ill ever since, the last six years spent on dialysis.

Unfortunately, dialysis became less and less effective as time went by and now a transplant is a necessity if he is to live. He has been on the kidney recipient list for over a year, but there hasn't been an exact tissue match. Diane — one of 10 children to Artie and Delores Dromerhauser — is the only one in the family who matched 100 percent in tissue typing.

"When I was 16, my whole family was getting tested and everyone turned up unable to donate a kidney to me," Diane said. "Since I was a minor they didn't even think of me. They said I was too young. But I begged and begged and when they finally agreed, they found I matched up."

"And from that point on I was never nervous and I just kept pursuing it, saying 'I want to be the one. I want to be the one.' I never really gave it a second thought."

The decade that separates her and Artie, though, has done nothing to cloud the memory of the good times they shared. She remembers him driving her to school and teaching her to bat and throw — talents that have helped Dromerhauser excel on Bay Shore's league-leading softball team. But the sight she recalls most is seeing Artie come home from college one day with dark circles under his eyes and having lost considerable weight.

"I was 11 years old and I never forgot that day," she said. "I never forgot how helpless it makes you feel. That's why I want to do something for him. Because I'm able."

"We think what she's doing is incredibly brave," said Artie Dromerhauser Sr. "I remember how nervous my wife and I got when we sat down with the entire team of surgeons at Stony Brook Hospital a while back and the first thing they asked Diane was,



Diane Dromerhauser, surrounded by family, will donate a kidney to an ailing brother (not in photo) Newsday / Julia Gurnea

"Are you ready to die?" Of course, they finally came full circle but my wife and I were just so scared."

Not Diane, though. Since the time she has decided to follow through with her decision, she said many classmates don't know what to say to her. Some mention how brave she is. Others mention that they would have a hard time doing the same thing. "But most just say, 'Wow,'" she said.

"Really, the decision is a simple one," she said. "I love my brother and I would do anything for him."

Mr. DOWNEY. Thank you. Ms. Block?

STATEMENT OF REGINA BLOCK

Ms. BLOCK. Hi. My name is Regina Block and I'm here on behalf of my mother Barbara Dalla Chiara who couldn't make it here today.

My mother was employed with Wendy's in Jericho, New York when she was diagnosed with having a form of cancer called Multiple Myeloma. She was out of work for approximately 3 months while she was recovering from her initial diagnosis.

When she returned to work her employer approached her saying that they wanted to change health insurance carriers because it was just too expensive to keep the present insurance that they had. They told her that with her pre-existing condition it was just too expensive to have her under group coverage, and that if she applied for a policy, an individual policy under Blue Cross, Blue Shield, they would pay her premiums and they could obtain group coverage under a cost effective rate.

She filled out the application for Blue Cross, and was ultimately denied because she was still employed and eligible for group coverage. Two months after she advised her boss of the denial she was fired from her job, and 2 months after that her employer changed health insurance carriers.

She didn't know much about insurance when this offer was made to her, so she contacted me, I do medical insurance billing for a living, and I told her it was a great thing that her employer was doing due to the fact that there was going to come a time that she would not be able to work any longer, and if she already had an individual policy with Blue Cross and Blue Shield the only thing she would have to do is take over the premium payments and she would never have to worry about being under COBRA for 18 months and worrying what she's going to have to do after the 18 months run out.

Well now the 18 months are running out in June and we don't know what we're going to do for health insurance coverage. In October we applied for an individual policy under Blue Cross knowing that her COBRA was going to be over in June of '92. We were told by Blue Cross that she would virtually have to be without insurance for 11 months before they would cover her for any of her conditions. So she still cannot have insurance under Blue Cross.

She can convert her policy into an HMO, the present policy that she has, however, she's not going to be able to see her own doctor anymore under this HMO because he's not with the HMO. She's going to lose all her drug coverage, her chemotherapy will not be covered. The only thing that will be covered under this HMO will be her hospitalizations, but that doesn't matter because her drugs are literally hundreds and hundreds of dollars a month.

Also, my husband and I have been forced to buy her house because we have been advised by lawyers, doctors and social workers that we must get all of her assets out of her name. So we had to buy her house, giving her the money, and in turn she's going to have to sign all her money back to us just so she will not have anything under her name because this way now she might be eligible

for some public assistance. She virtually has to impoverish herself to get any kind of coverage. The only thing she's ever had is her home, she's worked all her life to keep her home and now she doesn't even have that any longer.

I think that's all I have to say. Thank you.

[The prepared statement of Ms. Block follows:]

Long Island Progressive Coalition

Citizen Action on Long Island

1 Ireland Place
Amityville, N.Y. 11701

516-691-3689
516-691-5565

Regina Dalla Chiara Block
Testimony before the Select Committee on Aging
Subcommittee on Human Services
January 14, 1992

My mother, Barbara Dalla Chiara was an employee at Wenco Food Systems (a division of Wendy's International) in Jericho, NY. In September 1989, my mother was diagnosed as having Multiple Myeloma (a form of cancer). She was out of work from September 1989 until the beginning of December 1989, at which time she went back to her old job duties.

A few months after my mother returned to work, her boss approached her and told her that Wenco wanted to change insurance companies because the company they had at the time (Metropolitan Life) was too expensive and that they wanted to go to another group insurance. It was at this time, my mother's boss, Marybeth Marsar, told my mother that due to my mother's illness, it was difficult for Wenco to obtain insurance at a cost effective rate. She then asked my mother to apply for an individual policy with Blue Cross and Blue Shield, Wenco would pay the premiums for her and obtain group coverage through another insurance carrier. Paying for an individual policy for her along with the group coverage for the other employees, ultimately, they felt, would still be cheaper for Wenco, rather than having my mother under the group coverage.

My mother, like most people, did not know much about health insurance issues. She contacted me at work and asked me what I thought about the offer that was made to her. Since I do medical insurance billing for a living, she felt that I was the most qualified person to seek advise from. I told her that I thought it was a great idea, due to the fact that there will come a time that she will no longer be able to work. When that time came, she wouldn't have to go under the COBRA plan and have to worry about obtaining insurance after the eighteen (18) months were up under COBRA. If she already had an individual policy with Blue Cross, when she finally left her job, she would then have to take over the payments. She would never have to worry about her health insurance coverage. My mother's employer filled out the application for Blue Cross and had my mother sign it. Unfortunately, Blue Cross denied my mother coverage because she was employed and therefore eligible for group insurance. My mother advised her boss of the denial, two months later she was terminated from her job (Wenco said due to cut backs, even though they were opening three new stores and she was the only full timer in pay roll), and two months after that, Wenco changed health insurance carriers. It was possible for them to obtain a decent group rate with the new health insurance carrier, due to the fact that they only have to have her under the plan for the standard eighteen months under COBRA.



Testimony of Regina Dalla Chiara Block
House Select Committee on Aging
Subcommittee on Human Services

After her COBRA runs out in June 1992, my mother can convert her insurance to an individual policy. The problem with this is:

1. She can only convert it to an HMO. Under this plan she will not be able to use the doctor she has had since she was diagnosed with cancer.
2. She will lose her prescription drug coverage. They do not cover any medications what so ever. They still haven't been able to advise me if her monthly chemotherapy will be covered. She has to be admitted to the hospital for five (5) consecutive days per month for treatment. The hospital will be covered, but we don't know about the chemo drugs, which are literally hundreds and hundreds of dollars.
3. She will lose her durable medical equipment coverage. This means if she needs a wheelchair, cane, or hospital bed, none of it will be covered.

To date, I have not been able to even get a price on what this coverage, if you can call it that, will cost.

We sent another application in to Blue Cross in October, 1991. We know that Blue Cross has an eleven (11) month waiting period on pre-existing conditions. We figured that if we applied then, if she was approved for coverage for example in November of '91, that by October of '92, Blue Cross would start to pay for medical services she required. We thought that in June of '92, we would convert my mother's policy to the HMO and keep that until October when the Blue Cross kicked in. In essence, we were going to pay Blue Cross almost \$3,000.00 for coverage for one year that they weren't going to cover anything. All this money for them to do absolutely nothing. I was advised by Blue Cross that my mother would have to be without insurance for eleven months before she would be covered by them. That means that she would use her COBRA until June '92, then apply to Blue Cross, once they approved her application, she would then not have any coverage through them for her pre-existing conditions for eleven months. Boiled down, this means that they still get almost \$3,000.00 for doing nothing, but now for eleven months, my mother would have to pay for her doctor bills, prescription drugs, hospitalizations etc. out of her own pocket.

This to us is an absolute disgrace. That this could happen in the United States is unconscionable. I have joked with my mother over the past few months that I was going to pack her bags and move her to Canada. This is not a joke anymore. We have five months to find an insurance company that will cover my mother.

Testimony of Regina Dalla Chiara Block
House Select Committee on Aging
Subcommittee on Human Services

My husband and I have bought my mother's house and have moved in with her. There are a number of reasons that we did this:

1. My mother can no longer afford to live on her own and pay her mortgage.
2. We have been advised by social workers, doctors and lawyers to get all of my mother's assets out of her name.

We looked into applying for Medicaid for my mother. They go back thirty months (30) in your financial records and want to know what you did with the money from the sale of your house, or why all of a sudden were there big withdrawals from the bank on this date or that date, etc. You can only have a certain amount of money in the bank. There is no other country in the world that you have to impoverish yourself before you can get any kind of help. Other countries take care of their elderly and their infirm. These people don't have to sell off their homes, hide money etc. They give their loyalty to their country and are taken care of, what do we get?

Like most people, my mother's only asset is her home. She doesn't have any kind of money in the bank. The only thing that she could truly call her own was her house and now she doesn't even have that any more.

We need the Russo Bill so that people like my mother will be able to have some peace of mind while they are fighting these horrible illnesses. A big issue now is that people want to "die with dignity." The Russo Bill will help people "live with dignity."

Thank you for your time.

Regina Dalla Chiara Block

Mr. DOWNEY. Thank you. Mr. Leotta?

STATEMENT OF JAMES LEOTTA

Mr. LEOTTA. Good morning. My name is James Leotta and I am senior partner of Paradigm Design Systems Incorporated. Paradigm Design Systems manufactures accounting and reporting software for non-profit organizations. The bulk of our clientele are organizations that provide mental health care throughout New York State. Paradigm employs five persons at this time and expects to add another three employees this year. I'm here today in support of H.R. 1300, a bill entitled the Universal Health Care Act of 1991.

In July of 1991 Paradigm Design Systems incorporated and moved into our new offices in Port Jefferson. At that time we began our search for a health care policy. It took Paradigm 4 months of numerous nationwide phone calls, meetings with insurance agents and countless hours of staff time comparing the fine print of policies to come up with one policy which we could afford but which could only be classified as mediocre at best.

For that policy we are paying an average of \$1,550 per year per employee not including family members, which employees must pick up on their own. Our policy has a \$1,000 deductible per employee of which Paradigm will reimburse 75 percent. This raises our possible health care costs per employee to \$2,300 per year.

Paradigm's health insurance policy does not cover routine physical exams, immunizations, vaccines or anything else related to preventive care. It does not cover any dental work, it does not cover eye care, and it does not cover prescription drugs. It is basically just a guarantee that if any staff members get extremely sick and are hospitalized they won't have to file for personal bankruptcy because they can't afford to pay their doctor and hospital bills. And that is only if their illness is a new one. Pre-existing conditions are not covered at all until that staff member has worked for us for at least 6 months for most illnesses. And if that illness is something like cancer, our insurance company will refuse to cover that individual completely.

For staff members with families, their additional cost average \$325 per employee, per month, \$3,900 per year, plus the 25 percent of the deductible bringing their out-of-pocket expenses to \$4,150. For someone making 18,000 annually with a take home pay of approximately \$15,000, that is equivalent of over 3 months salary. It's really no wonder that low income families in America do not have health insurance.

Another problem with private health insurance is discrimination. The policy Paradigm obtained, with every policy we looked at except Blue Cross, Blue Shield, had different rates based upon age. The policy we chose, however, did not have different rates based upon sex. Most of the other policies we looked at did. In some cases it would have cost us \$1,200 per year more for each female employee, that is on top of the additional sex differentiated cost employers must pay—unemployment insurance and disability, et cetera. From a strictly economic point of view, how can one expect equal opportunity for women, especially in these recessionary times, where

every expenditure is scrutinized and the cost of having a female employee rather than a male can be thousands of dollars more.

The numbers I have presented are high, yet become higher still if any one of our employees ever use their health insurance. We have been told that if we use our insurance for extended illness our rates would climb dramatically or worse we would be dropped altogether in which case Paradigm would have to begin the whole cycle again. So much for shared liability.

So what is the bottom line? How can you expect small companies with creative ideas for new technologies to compete in the world marketplace when you have straddled them with the unfair disadvantage of uncompetitive costs because they must bear the burden of a private health care system that is monetarily out of control.

How can business in this country compete when the following occurs: One, unlike Japan or Germany every product made in this country and every service offered by this country must include an overhead, the staggering cost of private health care.

Two, unlike every country in the European Economic Community, every product made in this country and every service offered by this country, must include as overhead the staff expenditures for dealing with the abundance of paperwork for health insurance claims for health care.

Three, unlike every major economic country in the world, the pool of qualified employees continues to decrease as thousands and thousands of children in our country sit in classrooms everyday with ear infections or painful dental cavities or sore throats unable to effectively learn because they are sick and whose parents cannot afford a doctor to make them better.

This country, if it is to survive as a major economic force in the world has no choice but to institute a national health care plan. We can no longer subsidize the burgeoning bureaucracy of private health care. H.R. 1300 provides business with lower budgetary costs and extensive care. It eliminates discrimination based on sex, age, and pre-existing medical conditions, giving business the ability to choose the best employees.

Finally, H.R. 1300 will free business to pursue our own business instead of having to become health care contract specialists, which is now the case.

I wish to thank the chairman and the members of the committee for holding these important hearings and granting me the time to speak before you today.

Mr. DOWNEY. Thank you, Mr. Leotta. What sort of information do you have to provide the health insurance companies when you're looking for policies?

Mr. LEOTTA. Everything about yourself, your background, how many people you have, their sex, whether you have children. Primarily they're looking for whether you have had a pre-existing condition for the most part.

Mr. DOWNEY. Is it possible for a small company like yours to get health insurance policies that provide preventative services?

Mr. LEOTTA. No, not without paying an astronomical cost beyond our budget. Already we're up against the wall with this.

Mr. DOWNEY. How about HMO's, are they a possibility?

Mr. LEOTTA. We spent, as I said, 4 months, reviewing the different questions concerning different health care policies. And the one we have was the only one we could afford that provided a basic level of care meaning that you could go to any doctor you wanted to go to and provided some freedom as far as a choice of where you went. But again, it's only if you have, you know, extended illnesses that it really kicks in.

We decided to subsidize the 75 percent deductible in order to give our employees some dental work and some eyeglass, they can bring in bills from any doctor and we'll pay 75 percent up to a thousand, it was \$750 annually.

Mr. DOWNEY. What are the expectations of your employees or prospective employees with respect to health coverage, I mean do you find yourself at a disadvantage in terms of the policies that you offer?

Mr. LEOTTA. Oh, definitely. I mean, for instance, there was someone I was looking at when I wanted to offer a job to and who worked for another company. I know I can't do that, I mean that person would be crazy to leave that company. Even if I offered them more money, they would have to give up extensive benefits that they have at the larger company, or working for the State or working for the U.S. Government than to come to work for us.

So we have, as I call it, we have a stagnation of the employment pool. We don't have the mobility anymore of people being able to move from job to job because of this type of policy that exists. So people are somewhat forced to stay where they are. Small companies can never compete against the big guys by getting in that pool.

Mr. DOWNEY. Are other businesses your size facing similar problems?

Mr. LEOTTA. Everyone I spoke to, every business I spoke to.

Mr. DOWNEY. Have you ever thought of any sort of collective action?

Mr. LEOTTA. Yes, I have. In fact, I have spoken to some businesses. One of the problems I have is that if a business like ours, we're concerned about sex discrimination and some other businesses aren't as concerned, and it's hard to find a philosophical middle ground. Everyone would agree on a cost for a policy basically. We're having a hard time finding people that are willing to spend a little bit more to get a lot more for their employees.

Mr. DOWNEY. The President's Chief of Staff has suggested that additional tax credits for employees might be made available. What is your reaction to that?

Mr. LEOTTA. Tax credits for employees?

Mr. DOWNEY. To purchase health insurance.

Mr. LEOTTA. I think that's just going to be a short term solution. How much tax credit can you give back to people? I think the problem is the structure of the system and the fact that you have a huge group of people that are reaping large amounts of profits off basically a billing system, as far as I'm concerned.

I think it needs to be streamlined. And I think giving that person a tax credit, if you look at what we have to pay now, the amount of money we're talking about, I said 3 months of someone's salary in order to purchase family coverage. How much of a tax credit can you give them in order to go out there and be able to purchase it?

And that's still not including dental or any preventative care whatsoever.

Mr. DOWNEY. One last point. You said that if you use your insurance your rates climb. Does that mean if there are catastrophic illnesses or just if the policies are being used?

Mr. LEOTTA. Any extensive use of the policy, which I can't even budget because I don't know what those rises are going to be. I'm just told, almost warned or threatened, not to ever use our health insurance because if we do, we can face non-budgetary costs. I have no idea what those rates are going to be if we do use our insurance.

Mr. DOWNEY. Thank you. Ray.

Mr. McGRATH. I first and foremost want to thank the panel for coming and sharing with us your experience. I appreciate your testimony. You made a tremendous contribution to our deliberations here.

I can't help but think in listening to the testimony that cost is a major consideration here. And as we've looked at the average cost in an employer-based system as we have today, for an employer to provide insurance for each of his employees and where that's gone over the past, let's say, 5 to 10 years.

Approximately 10 years ago, and let me first say that in an employer-based system for the same reasons that you have pointed out, Jim, there is a great incentive to provide health benefits and other benefits to employees.

First of all, you can attract good employees and you can retain them with the provision of these benefits. At the same time each employer for every cent that he pays towards the premiums for those insurance bills, gets a dollar for dollar deduction from his corporate liability. It's a health incentive.

At the same time that incentive becomes less and less attractive to an employer when the cost per employee for a family goes from an average 10 years of \$785 per employee for his family to today the average across the Nation is \$3,300, in this region because of high costs is \$5,400. And it is projected by studies recently enumerated in the Wall Street Journal that same cost to cover that same employee and his family in the year 2000 will be \$22,000 per employee.

So the incentive becomes less and less of an incentive when the costs rise that dramatically. You have to make a heck of a lot of money in order for that deduction to be worth as much as it was worth 10 years ago. So necessarily we're going to have to do something about cost.

Interestingly enough though, in any plan that we may come up with, including a national plan or some combination or permutation of that plan, cost is going to have to be borne by somebody, whether it be an employer, a combination employer or beneficiary, or the taxpayer.

I'm interested, Artie, in your testimony that you did point out in your son's case the reimbursement for the renal dialysis is borne out of Medicare, 80 percent of the cost is borne out of Medicare. It is the only malady paid for by Medicare that is not a service for somebody 65 years and above. And it was put into effect in 1972, before Tom and I were in Congress, for specifically that purpose because of the catastrophic nature of this particular disease.

And frankly, because of the cost, it costs somewhere in the neighborhood of \$137 per procedure now, I don't think that we would be able to find another disease that we would do this for out of Medicare for somebody less than 65.

On of the big problems in access today is covering people who are on Social Security and retired at age 62 and can't get any coverage from Medicare until they're 65. As an interim step perhaps, and I don't believe frankly whether we pass this bill or another bill or some other bill, that we're going to snap our fingers and say on January 1st of the following year this new plan will go into effect. I don't believe that's the way it's going to happen whatever we do. I think it will be some incremental approach, some narrowing of the people who require access to the system. I think that's probably the way it's going to go, and on the cost side perhaps that's the way it's going to go too.

I just wanted to share with you the fact that regardless of whatever system we decide to go to, it's going to cost somebody something. Whether it's going to cost the taxpayers or the employers or as Senator Mitchell has put together a plan which says play or pay, employers you play at the system, provide this benefit or if you don't pay the government so that they can provide too.

So there's an awful lot of plans out there, the Russo plan being one, Mitchell's plan, Rockefeller's plan. There's a Heritage Foundation plan which Tom talked about in terms of providing a tax credit to allow each individual to go out and buy whatever insurance they want based on their own experience. All of these things are being considered. None of them are being disregarded.

But at the same time, it is testimony like yours that brings into focus the need to do something and do it quickly. Thank you.

Mr. DOWNEY. Thank you, Ray. Mr. Leotta, did you want to say something?

Mr. LEOTTA. Yes. I just want to say that after I looked at all the bills what I liked about 1300 was the fact that it was budgetary, it seems cheaper to me for a business to pay, looking at all the other bills that I've looked at, it doesn't put an unfair burden on employers. The percentage that I would have to pay to me seems quite fair and I can plan for it, and that's really important.

The other thing is it's not just cost. It's the ability to hire the best employees. I can't hire the best employees all the time if the continuing system continues in the direction its going and female employees I would be very reluctant to hire in the future.

Secondly, anybody with a pre-existing illness I could never hire them either. If this person was a brilliant programmer and I wanted to hire them, I could not do it because I cannot offer them the health care for them. So it's really not just cost, it's cost and that freedom to choose the best employee.

Mr. DOWNEY. Artie, I realize how hard it is for you to come here today and explain what has happened to the family. Do you ever get the sense that if you had been in another country, if you had been in Germany or some other country, this problem would just not have faced you. I mean it seems to me a glaring weakness of our country, and you're the example that I talk about frequently, that you'd be paying for the phone bill in a Canadian hospital and that would be it with this system. There are flaws in the Canadian

system clearly but we just don't treat people like this or force families into being completely unmanageable and unacceptable situation they have.

Ms. Block, we will continue to monitor what happens to your mom. But I only wish that to her and to the unemployed Pan Am workers or folks who have been working for Grumman or AIL or Raytheon that there was some short-term answer.

I think between where we ultimately wind up, and it's my hope, Mr. Leotta, that it is with H.R. 1300, that still some interim step is absolutely essential to deal with the crisis that is on us right now. I want to thank the three of you, your testimony has been tremendously helpful and I appreciate you taking the time. Thank you.

Mr. DOWNEY. The Subcommittee will next hear of a panel comprised of Ted Jospe who is the President of Southside Hospital in Bay Shore, Dan Walsh who is the President of Good Samaritan Hospital in West Islip, and Martin R. Liebowitz, M.D., Governor, New York State, Downstate Region II, American College of Physicians.

PANEL TWO, CONSISTING OF THEODORE JOSPE, PRESIDENT, SOUTHSIDE HOSPITAL, BAY SHORE, NY; DANIEL WALSH, PRESIDENT, GOOD SAMARITAN HOSPITAL, WEST ISLIP, NY; MARTIN R. LIEBOWITZ, M.D., FACP, GOVERNOR FOR NEW YORK DOWNSTATE II, AMERICAN COLLEGE OF PHYSICIANS, STONY BROOK, NY

STATEMENT OF THEODORE JOSPE

Mr. JOSPE. Thank you Congressmen Downey and McGrath for hosting this hearing on health reform. It seems that everyone agrees that the time is right for health care reform and we agree as well. There is some question, however, as to what is health care reform. It obviously means different things to different people.

For business, health care reform means lower health insurance costs. For small businesses it means the dilemma of even finding affordable insurance, as we just heard. For government, health care reform may mean controlling costs while attempting to provide services for everyone. For patients and communities, health care reform means access to affordable, accountable health care services. For hospitals and other health care providers, health care reform means finding a way to balance patient and community health care needs with available resources. And I will tell you that for my own institution I haven't yet discovered what that balance is.

There are many aspects to health care reform, but our primary focus must be on improving the health status of society, must be on meeting the health care needs of our patients and communities. Health care reform must address the current failings of our health care system, failings which impact on the quality of life and the health of all of us. The operating environment to which such a strategy would be introduced must be seriously considered.

As you know, in New York State we deal everyday with the realities of caring for our communities. We are experiencing four concurrent epidemics and this affects not only urban New York but, I would support to you, here in bucolic Suffolk County we have

the elements of these four concurrent epidemics. They are as follows: tuberculosis, syphilis, measles and AIDS. The dimensions of the epidemic are yet to be known, but we all expect them to broaden. Patient characteristics are complicated by societal issues such as substance abuse, mental health, poverty, and the challenges to the health system are immense.

This undeniable need is brought to the doorstep of a hospital community already half a billion dollars in debt and at risk of upward of an additional \$1 billion in provider cuts in this year's State budget crisis alone. We are burdened with trying to carry out a mission without sufficient financial support. The prices hospitals pay for technology and supplies and pharmaceuticals, for example, far exceed inflationary adjustment recognized by insurers and other payers. It is a very deep hole complicated by a seemingly insatiable appetite on the part of government to take a short term view of problems and solutions.

It is not surprising to note, then, as government retrenches at all levels and community services are reduced, the one remaining safety net for society has been the hospital. Reform agendas need to recognize that this valuable community resource needs help in fulfilling its mission.

On this particular occasion I speak from two separate perspectives. I'm President of Southside Hospital, which is a 489 bed acute care facility in Bay Shore, and I also serve as the Chairman of the Hospital Association of New York State.

Health care reform for too long has meant financing reform and controlling costs. It has been too long since the design of the health care system has been re-examined to answer very basic questions. Is it meeting the needs of our citizens? And I believe we just heard quite succinctly that it is not meeting those needs. Is it available to everyone? And again obviously, no, it's not. Is it improving the quality of life and health of our residents? Overwhelmingly the evidence, the statistics, the people tell us it is not working well enough to be comfortable with the answers that we get from these questions.

We, all of us, providers, government, regulatory authorities, business, labor, consumers, now have an opportunity to undertake meaningful reform of our health care system, an opportunity to improve the life and health of our citizens. But to do this we must look at a number of elements of our health care system from access to the regulatory apparatus, to financing mechanisms, to the design of the delivery system, to how we enhance quality of care.

In our efforts, however, we must keep two critical points in mind, the health of patients in communities must be the focus of decision making and we must all work together to achieve a consensus and work toward incremental progress for reform.

The New York State health care community has worked together to create a vision for the future of our health care system. The elements of this vision are included in a document called "Health 2000: A Vision for Meeting Community Health Needs." Before I provide a brief description of these elements, let me just say that we view Health 2000 as a starting point to begin a dialogue on the essentials of health care reform. It is intended to stimulate discussion and to raise questions and issues with the ultimate goal being

to achieve consensus on the key components of the future health care system.

The focus of Health 2000 is patient and community health care need and it includes the following elements: Universal Access. Improving our communities access to quality health care services is essential if the goal of improving society's health is to be achieved. One of the best methods for achieving this is through implementation of a universal access system. Let me point out that expanding access should ultimately reduce systems costs because health care will be delivered when it is first needed as opposed to when the need is most severe.

Second, Regulatory Reform. A key element in approving the efficiency and cost effectiveness of the health care system is eliminating regulations that are counter-productive to providing quality patient care. The Hospital Association has developed a regulatory reform package of over 200 constructive ideas which envisions a new partnership between the health care community and its regulators, one based on collaboration and mutual respect. Our goal is a regulatory system that promotes and rewards efficiency and efficacy in the delivery of health care services.

Just as an aside, in New York State we have 164 separate agencies which provide us with regulations about how we should conduct our business as a hospital.

Financing reform is also essential. In order to achieve a more equitable and fair payment system, such reform must reflect the principals of equity, stability, simplicity, flexibility, and predictability. Financing reform strategies must recognize the essential role of positive, constructive incentives in moving the health system towards social desirable goals. Simply saying that we must do more with less will not achieve a more healthy population.

A key ingredient of reform must be a redesign of the health care delivery system. The design of the system should focus on the patient as the center of decision making and should promote a coordinated managed approach to patient care. A conscious effort to establish a true continuum of care through vertically integrated health care systems is essential. Hospitals are essential to the establishment of such systems.

Quality Enhancement. The New York State health care community believes that moving toward continuous improvement and quality is the ideal method for enhancing quality of care. However, while the state-of-the-art for continuous improvement is still being perfected, hospitals are building on their current quality management activities. In particular, hospitals are working to continue to implement and use research tools that enhance clinical decision making. These research efforts, as well as other health care information, must be translated into useful tools for consumers in their health care decision making process. I'll tell you that right now that translation process is ailing and it's not a good translation, at least not up until now.

National Health Insurance Proposals. One of the themes in Health 2000 is so-called getting back to basics, and the basic question to answer regarding universal coverage is what kind of coverage, what kind of access to what kind of service.

In designing a national health insurance system benefits should correlate with patient outcomes, that is, benefits should be designed to make a difference in one's health status. This would place an emphasis on primary care and prevention. I would also recognize a contribution of physician and hospital care and would include emergency care, home health services, mental health services, and catastrophic care. Furthermore, whether long term care is included right away or phased in or handled separately, its consideration reflects the reality of demography now and even more so in the future. Again, an oft heard statistic for at least the bi-county area is that we are some several thousand beds too short in the provision of skilled nursing care to the elderly. That's here in Nassau and Suffolk Counties alone.

Finally, irrespective of the specifics of benefit design, it is also clear that the contribution of lifestyle to prevention of disease and management of illness is well-known. In fact, it has been estimated that 30 percent of hospital admissions have an underlying lifestyle problem. I believe that 30 percent is a very modest guesstimation, and it may even be something like twice that number.

The design of the financing system. Three basic principles should govern the financing scheme of national health insurance, and they are, one, to retain the present pluralistic structure of the health care system. And admittedly, that may be an arguable suggestion.

It is more efficient and more realistic to build upon existing mechanisms than to create radically new ones with a fulfillment of these goals. For example, some of the major health insurers, in addition to being proficient in handling billing and administrative matters, are experienced in the effective application of utilization controls and managed care programs.

Second, to use current health insurance, including that obtained through employment, as a base for support of the program. Funds to implement such a program, particularly public funds, are going to be difficult to obtain in view of current and future Federal budget problems. It's not just Federal budget problems that we're talking about.

If the program is going to be implemented in the foreseeable future, it is essential that private funding sources remain and indeed be enhanced rather than shifting to a public funding source for those costs currently paid by employers and those otherwise able to pay.

Employers not currently providing health insurance should participate in the funding for such insurance because barriers to health care services affect the health of their employees and their employees' dependents. Individuals participating in the program who are not covered through employer-based insurance should contribute to the cost of insurance coverage according to their income level.

To phase in program components gradually is another essential element to ensure that sufficient providers and resources are in place to meet what we anticipate will be increased demand for services.

A system that simply promises coverage will not be enough. Access will be ensured only when sufficient resources and provid-

ers are in place to handle the additional demand. The components of any health insurance proposal would be phased in gradually to allow the needed resources to be put in place so that the health care system, which is already in crisis, will not be endangered.

In considering any national reform proposal, we suggest that the following principles guide the discussion: First, the patient in the community should be the focus for decision making. This means that the performance of government, the insurance industry, the hospital community and others, will be measured by how we collectively affect the health status of society. It also suggests that any national program include sufficient flexibility to allow the unique needs and characteristics of different parts of the country to be responsibly considered. New York cares for an indigent population with complex problems reflected in the cost of doing business here.

Second, societal goals for health need to be established to provide a framework for debate on the proper matching of expectation with reality. This requires an agreed upon national vision as to where the health system should move and which goals it should set out to achieve. The mobilization of other energies to solving problems such as improving our infant mortality or childhood immunization experience would make a clear statement about priorities.

Third, constructive incentives should be introduced to meet socially desirable goals. Contrary to historically punitive approaches, this recognizes that professionals will respond to positive incentives. In other words, we should be looking towards the carrot approach not the stick approach.

Fourth, removal of all unnecessary overhead must be pursued before looking to cut services. The health care system has become so complex that patients have become sickened by, and professionals dispirited by, the rules that govern their behavior. In fact, lawyers, accountants and consultants thrive on trying to make sense out of this system.

Just as an aside again, we just got a rate sheet from the State about our Medicaid calculation, a rate calculation sheet, contrary to what the name implies, you would think it's a single piece of paper with some numbers on it. It is a document that is over 160 pages long. It's incredible.

Fifth, there must be a commitment to continuous improvement in quality from every sector in health. This not only asks providers to collaborate with business in pursuit of quality management models, but recognizes government, insurers, and others to embrace the same pursuit of excellence.

Sixth, we must show a demonstration of value, a return on the investment for each dollar committed to health. This speaks to efficiency, productivity, and efficacy from all sectors. It also recognizes that social institutions are to be mission-driven and should be business-like.

Seventh, there must be an ability to maintain a long term vision irrespective of short term expediency. Health reform may require compromise of approach but not of ideal.

Bringing about reform is not going to be easy, but the New York State health care community is committed to forcefully advocating for significant reform. Being proactive in this manner means more than merely taking the initiative or going on the offensive. In its

broadest sense, this commitment means assuming responsibility for acting on one's values. In the context of the health care community, it means that we actively work to alter the environment in such a way that our mission of service to our communities can be fulfilled.

The hospital community stands ready to collaborate with all those interested in health in pursuit of this noble goal. Thank you again for the opportunity to address you.

Mr. DOWNEY. Thank you, Ted. Dan?

STATEMENT OF DANIEL WALSH

Mr. WALSH. My name is Dan Walsh. I am President of Good Samaritan Hospital in West Islip, New York. I wish to again also express my appreciation to Congressman Downey for the invitation to attend the hearing on "Long Island's Response to America's Health Care Crisis."

The purpose of the hearing is to focus on what are the failures of the current health care system and this is appropriate. By discussing such failures we hopefully can begin to construct solutions to them. However, such solutions cannot ignore what is currently worthwhile about the existing health care system. The foundation for change should be based on maintaining what is presently effective, and developing solutions and proposals to reduce or eliminate existing deficiencies.

So we ask, What is good or worthwhile about the current system? I believe there is much to be proud of and suggest the following as two illustrative examples:

First, highly trained and technically skilled physicians, allied health care professionals, and support personnel who are committed to providing quality care services to patients in need.

Second, a broad array and distribution of hospitals where patients can receive personal and compassionate care from professional staff and have access to diagnostic and treatment technology only dreamed of years ago. Patients are now treated quicker, less invasively, and recover more quickly than ever before.

The advancements in quality and technology in the current health care system have contributed in part to some of its existing problems. People are living longer with greater health care demands. We can do more for patients than ever before, and there is a public expectation for the best available health care services. To some extent, we are the victims of our own success. I do believe that the quality of our health care services for those patients who can access the system is excellent. But professional and technological advancements are expensive while resources are limited.

The mentioning of limitations naturally turns our attention to some of the failures existing in the current health care system. Again, I suggest the following as illustrative examples:

First, as was mentioned previously, there are access problems caused by a lack of health care insurance or the financial means to purchase services. The data is well publicized that approximately 30-35 million Americans do not have health care coverage even though two-thirds not covered do have some linkage to the work-

force. Health care services are available but not accessible because of financial or health care coverage limits.

Second, the continued dramatic rise in health care costs is a major problem and the more health care costs rise, the greater the focus on controlling such expenditures. Since the current health care system has a multiplicity of third party payers, much gaming is occurring to cost shift as a means of controlling expenditures for that particular payer. As a result, government attempts to cost shift to private payers. Private payers, in turn, attempt to cost shift among themselves. And finally, employers cost shift to their employees with higher deductibles and co-payments. Since there is a close intertwining between access and financial resources, as cost shifting occurs further inequities and access to services occur as these selective types of cost controls are intensified.

Let's turn to the question of what to do now? Reform proposals which are being discussed are mind-boggling in their diversity and number. Generally, they are categorized to facilitate discussion and analysis into three broad groups.

One, proposals for centralization. Either centralized financing for health care or centralized payment coordinator approaches or a combination of both of these aspects. The Russo bill is an example of this approach.

Two, proposals for maintaining a pluralistic approach but with more mandates, a so-called regulated pluralism. Various play or pay proposals fall into this category. The Kennedy-Waxman bill, which would require all businesses to provide health care insurance, with employers assuming the predominant funding role, is an example of this type of program.

Three, proposals for refinements in the current system, so-called incremental approaches. An example of this would be having government step in and increase health care access targeted toward the 30-35 million uninsured while keeping other components of the health care system relatively in tact. This approach is don't change the whole system to address problems in only certain areas.

Of these three broad categories, my preference is a variation on the three I would describe as incremental centralization. The basic premise here would be to centralize over time, only to the point necessary, to resolve major problems identified, then evaluate the outcomes and assess the next steps. I would suggest the following as initial steps:

First, movement to a single payment coordinator or paymaster seems a logical first move. Such a step would require standardization of insurance claim forms for both inpatients and outpatients. All insurance companies would furnish "standardized membership cards" to their enrollees which would conform to a predetermined format. This would greatly simplify paperwork for the individual insurance enrollees, just present your card, the health care providers, and also simplify it for the insurance companies. Savings in administrative costs, which have been theorized among these various categories, could be considerable using this approach.

The next step, I believe, would be to require greater standardization of health care benefit coverages among insurance companies. Such standardization would greatly facilitate centralized coordination of benefits activities by minimizing insurance coverage differ-

ences. These changes would certainly further simplify centralized administrative costs and also facilitate market comparisons by purchases of insurance products.

The administrative savings from a centralized paymaster system, once identified, could then be used as a funding source to address the needs of the uninsured.

After the above changes were implemented, the appropriate next step would be to evaluate the system and determine if further centralization is or is not necessary. I do not personally believe that centralized financing should be attempted until the above actions are taken and the outcomes of the system assessed.

I commend Congressman Downey and Congressman McGrath for their attention to this important issue, and again offer my thanks to both of you for the opportunity to present my comments on this important matter.

Thank you.

Mr. DOWNEY. Thank you, Dan. Dr. Liebowitz?

STATEMENT OF MARTIN R. LIEBOWITZ, M.D., FACP

Dr. LIEBOWITZ. Congressman Downey, Congressman McGrath. The New York State Chapter of the American College of Physicians is pleased to have this opportunity to present some of our views on the need for comprehensive health care reform. With more than 7,000 members practicing internal medicine and its subspecialties, the Chapter is the State's largest medical specialty. I am Martin Liebowitz, Governor for New York Downstate II of the College and Professor of Medicine at Stony Brook.

In May 1990 the College published an editorial in the *Annals of Internal Medicine*, that called universal access to health care a medical and moral imperative. The accompanying position paper entitled "Access to Health Care" identifies 16 criteria to be used in judging proposals for reform of the health care system.

Mr. Chairman, I request that a copy of that editorial and position paper be included in the record of this hearing.

Mr. DOWNEY. Without objection.

[See appendix, p. 98 for supplemental material submitted by Dr. Liebowitz.]

Dr. LIEBOWITZ. Since May 1990 the College and its 52 Chapters, including ours in New York, have been engaged in further analysis and discussion. We believe that comprehensive reform of the American health system is needed and that piecemeal approaches will not satisfactorily solve the interrelated problems of access, cost, quality, satisfaction and professional morale. We can delay no further the inclusion of all Americans in our health care system. And we urge this committee and the Congress to adopt that goal.

In the position paper, the College examined our health system and concluded that it has become, basically, dysfunctional. It is certainly not serving the 32 million uninsured Americans, not is it working well for insured patients, physicians, employers or government.

Like others, our initial motivation was the 32 million or more Americans who have no public or private health coverage. We were also struck by the Census Bureau finding that more than 60 mil-

lion people have inadequate coverage or gaps in their coverage. The January 4th New York Times pointed to the plight of those with defaulted or even fraudulent insurance. All told, one in four Americans may be exposed to the risk of catastrophic illness with little or no coverage.

On top of these problems with coverage, is mounting evidence that the health care system may be headed for fiscal collapse. The figures are now familiar to all, a total bill of \$756 billion, more than 12 percent of the GNP. Both figures are rising steadily but more and more needs are going unmet. In New York State it will be necessary to curtail Medicaid spending to balance the State budget in a time of recession. Close to home and painful for Long Islanders to contemplate, the Nassau County Medical Center has abruptly lost a large piece of its funding and will have to discontinue many services to the poor, the young, the handicapped, in other words, the vulnerable. Support for public health care institutions is eroding everywhere and Long Island is not immune.

One of the 16 criteria included in the ACP statement addresses the need to achieve administrative savings that a high proportion of program outlays are devoted to the delivery of health care services. Not only are we wasting the resources that are needed for patient care, but the burdensome nature of administrative requirements of current systems is a strain on both patients and providers.

Health care providers are subjected to complicated and different rules and requirements from a multitude of insurers and other third-party payers. As a result, hospitals, physicians and other health care providers must hire costly administrative staff and professional consulting firms just to prepare and process bills. This money is directly reflected in health care costs but yields nothing in patient care. Patients too are now utilizing the services of professional health insurance claim consultants. These kinds of administrative costs are intolerable especially at a time when employers, consumers, and government are seeking to curtail health care spending.

Consequently, the College looked very hard at the Canadian health care system. It concluded that there is much to be learned from the Canadian experience as we explore the achievement of universal access. While we envision a uniquely American system and do not believe that we can simply transplant the Canadian system, we were particularly impressed by the low administrative overhead of the Canadian health insurance financing mechanism and the lack of interference in clinical decision making.

The recent General Accounting Office study of the Canadian health insurance highlights the differences in administrative overhead and administrative costs between Canada and the United States. The report reinforces our assessment that savings in paperwork, billing, claims processing, responding to payment review and other administrative overhead, could more than offset the additional costs of expanding access to health care for all Americans.

Our Canadian members and colleagues are appalled by the financial obstacles, reporting requirements, and questioning the clinical judgment that U.S. physicians must endure. Administrative has-

sles, increasing interference in clinical decision making are not an effective means of cost containment or quality assurance.

The need to address the administrative overhead, therefore, is based on two compelling arguments. One is that the savings that can be achieved, 67 billion according to the GAO can be used to expand access. The second is that apart from the drain on our resources, the resulting administrative burden on physicians is taking a heavy toll on the profession. Being the only physician here today I must emphasize that. In fact, it can be argued that the micro-management of clinical decision making is a major factor in growth of dissatisfaction among physicians which, in turn, jeopardizes the Nation's ability to maintain an appropriate supply and specialty distribution of practitioners.

American health insurance practices are not only administratively complex but lack features that are essential to ensuring continuous health insurance coverage. The multiple examples already brought before you today.

Increasing competition in the health insurance industry has resulted in the virtual elimination of community-rated health insurance. As the means to identify insurance risks have improved and been refined, both not-for-profit and commercial insurers have proceeded to segment the insurance market offering lower-cost policies to healthy, low-risk groups and increasing premium rates for high risk groups and those with high claims experience. Consequently, individual, small groups, and others identified as being at high risk typically find that health insurance is either unavailable or unaffordable. Instead of spreading insurance risks widely among a large population, risks are isolated for each employer group.

Fierce competition for healthy groups produces low initial rates, but uncompensated health care for the uninsured causes cost-shifting as hospitals and physicians seek to recoup their costs. Disallowances of claims for needed services cause hardships for employees who change jobs or otherwise change insurance plans.

Meanwhile, the administrative, marketing, and overhead costs of insurance continue to increase and these costs are also passed on in the form of higher health insurance premiums. Attempts to curtail inappropriate and unnecessary health care services generate greater requirements for billing and claims processing, prior approvals, responses to utilization and other reviews and audits and increasing interference in clinical decision making.

Efforts to determine eligibility, ascertain co-payment and deductible obligations, avoid duplication of benefits, determine secondary and other payers add to the administrative costs and burdens. Clearly, it is time to examine insurance practices and develop substantial reforms in the industry.

We understand that even if administrative costs were reduced to minimal levels, there still would be elements in the system that would have to change. These include the payment system, the manpower system, investment incentives, the liability system, utilization and review and the role of the patient. This is an extensive agenda to change. In some areas good ideas are already on the table and must be further developed. In other areas we need to learn from others what might work and with appropriate modifica-

tion in this country. We do believe that the administrative overhead issue is central to these discussions.

As a medical educator, internist and firm advocate of primary health care, I want to point in my concluding remarks to a depressing contradiction in public policy. The College has from the start been a strong proponent of the Resource Based Relative Value Scale for paying for physician services under Medicare. It welcomed the implementation of a fee schedule that would give proper weight to the work of internists who provide the greatest amount of primary care in New York State.

The news that the all important conversion factor will be substantially reduced by a "behavioral offset" had produced dismay. The underlying blanket assumption about physician behavior seems untested, unwarranted, and indeed offensive. There is a real risk that RBRVS will be viewed as an artfully crafted fee reduction scheme rather than a means of establishing a rational basis for paying physicians for their work. The impact on primary care internists is particularly painful since RBRVS was expected to lend badly needed encouragement to primary care. At a time when it is a public, and indeed, a professional goal to encourage careers in primary care, the cynicism of this action is not lost on medical students and resident physicians.

Mr. Chairman, the American College of Physicians commends you for holding hearings locally as well as in Washington. The College looks forward to working with you develop a comprehensive strategy for reform of the health care system. Thank you.

Mr. DOWNEY. Thank you, Dr. Liebowitz.

Ted, Dan, and Dr. Liebowitz, I'm going to ask a series of questions to which you're all invited to respond.

Ted, you stated that for too long health care reform has meant cost containment and financing reform. Can you tell us, or Dan, or Dr. Liebowitz, how this emphasis simply on cost control and financing reform has affected the quality of health care on Long Island?

Why don't I just ask you a series of questions rather than the spectacle of you passing the microphone back and forth.

Mr. JOSPE. It kind of goes back to the old conundrum of someone who knows the cost of everything and value of nothing. The translation, the practical translation for the provider community has been that cost reform isn't really cost reform, it's reimbursement containment is what it is.

And even though constraints are put on our ability to achieve some fair recompense from the system there's no impediment to, for argument's sake, those individuals who provide goods and services to the hospitals market basket to be constrained in any fashion. So when Long Island Lighting Company rates go up 5 percent, our rates go up 5 percent. And that's irrespective of the fact that perhaps our reimbursement rate went down 3 percent.

There is no constraint in terms of limitation on labor, even though we recognize that there are large segments of the population who work for us who are indeed entitled to a living wage. These people work hard to achieve their expertise in that sort of thing, and should be adequately and fairly compensated. But yet if our rates are constrained, there doesn't seem to be a translation of a constraint on their expectation.

Mr. DOWNEY. So what it means is it comes out of you, I mean you have to do more fundraising, you have to change what, the nature of care that some people receive or others?

Mr. JOSPE. What you want, of course, ideally to do is to respond and have the most efficacious care you have, and in some ways that may, in fact, mean altering the way in which patients are cared for. Just in a very generic kind of an example, you've seen a shift from inpatient surgery.

Eight years ago when inpatient surgery was probably 95 percent of all the surgery we did in the hospital to now, same day surgery. And as a consequence of same day surgery the reimbursement for the provision of that service is less. It's probably better for the patient. And well over 40 percent of all of that surgery is now done in a different fashion.

So the fiscal constraint has kind of squeezed the balloon in a way that may render it an altered product, maybe even one that's a little bit better. That's perhaps one of the better examples.

The one thing that you always feel backed up against the wall about is doing anything that's going to interfere with the quality of that end product. So, yes, you're going to be as clever, innovative, or whatever, as you can, as you have to be, to survive to provide the kind of care that the people expect and deserve. But it doesn't always work. We're beginning to run out of widgets and alternative approaches. We're being squeezed to the point where we're beginning now to impinge on that core of quality that we provide.

Mr. DOWNEY. Let me ask you and Dan also to respond. How much uncompensated care does Southside provide, how much did you provide last year?

Mr. JOSPE. In 1990 we provided \$8 million of uncompensated care. It happened to correspond almost to the dollar with the loss that was experienced by the institution. Pursuant to the fact that my particular institution has experienced losses on that general order of magnitude, actually a little bit less, but not a lot less in years previous, it got to the point where we quite simply had to have some specific address made of this contribution to our community by the reimbursements by the State.

And so we achieved this special reimbursement status mid year last year that partially compensates us to a greater degree than the average hospital in the State for uncompensated care. But nonetheless, the order of magnitude of that uncompensated care prior to the application of this special reimbursement category was again on the order of magnitude of \$7.5 to \$8 million.

Mr. DOWNEY. What is it for Good Samaritan?

Mr. WALSH. I don't have a number for you, Tom, off the top of my head.

Mr. DOWNEY. Is it in that ballpark, is it less, is it more?

Mr. WALSH. It's certainly less than Ted's area at this point.

Mr. DOWNEY. And how do you pay for uncompensated care? You have fundraisers and other things like that, shift the cost to others.

Mr. WALSH. Uncompensated care when you use that term is a loaded terms in this sense in New York State. It includes a number of aspects. It includes something called compensation for bad debts, and compensation for charity care.

Strangely enough, there is a reimbursement for bad debts and charity care in New York State. But let's just say that someone is not that effective at collecting all their bad debts. You might have higher bad debts because your internal collections may not be as effective.

In the city sometimes they cut staff, they cut people in the patient accounts area and those are the people who collect accounts and bad debts went up, so they can publicize uncompensated care as a very large number. The true question is, What is a true charity care that you provide? And I think that's something that should be discussed more directly and openly.

Mr. McGRATH. Would you yield on that?

Mr. DOWNEY. Of course.

Mr. McGRATH. Ted and Dan both brought up an interesting highlight in their testimony regarding the magnitude of the regulations that they have to live with as administrators on Long Island and throughout New York State.

Interesting the question you've asked regarding uncompensated care or bad debt care or charity care, these institutions and every other in New York, and in my former life when I was a ranking Republican member of the Health Committee in the Assembly, we did a lot of this kind of work, we instituted a pool where about 3 percent, I think at that time, 3 percent of their receipts were pooled in order to compensate various facilities around the State for this kind of care for which there was no insurance.

Unfortunately, in places like Long Beach Hospital or Franklin General in my district or Mercy Hospital or South Nassau this contribution to this pool puts these institutions in somewhat precarious financial situations. And frankly, this care needs to be compensated for, but at the same time we have this very big problem of how to do it.

And I was, frankly, very interested in, Dan, your incremental centralization theory. It seems to me that in order for that to work you would have to preempt all State regulations, basically take the States out of the hospital business in order for that to work, and I was wondering whether or not that was part and parcel of your thinking.

Mr. WALSH. Not initially. Again, it does include the concept of taking all the various types of insurances and having them all pass through a centralized system at the Federal level. This would give the Federal Government an understanding of the diversity of health care coverages that are out there and by the data base for moving towards further standardization.

Mr. McGRATH. Secretary Sullivan has had a whole bunch of meetings with the presidents and CEO's of the various health insurance companies throughout the country and charged them to come up with some centralized claim form and whatever. But it does not attack the problem that each State or each insurance company in each State has, and that's simply this, that the State Insurance Commissioner in New York requires things to be reimbursed in New York that are not reimbursed in Pennsylvania and other States.

Mr. WALSH. Correct.

Mr. McGRATH. And as a result it becomes less and less an opportunity to consolidate. And if you have a common claim form when you have this kind of a situation that truly exists. So it seems to me if we're going to go in that direction, taking the States out of the system might be the only way of developing that formula of things that we're going to insure.

And, Dr. Liebowitz, I was interested in your testimony in terms of the necessity to begin to ensure things for prevention. It's ludicrous that we do everything on the acute side and do nothing on the prevention side when we know that an annual physical, which through a common blood test, can detect prostate cancer in males, a mammography can, on an annual basis for women, can detect long before they become acute and require radical mastectomies and other esoteric kinds of treatments, and colorectal screenings, a cheap little screening that can detect colon cancer before perhaps it becomes something that you have to detect with a digital kind of examination.

These kinds of things, in my view, are the things that a new system necessarily has to address. Not necessarily everything on the treatment when it becomes so acute that it's perhaps in some cases even ludicrous to treat.

Mr. DOWNEY. Let me just distinguish between indigent care and non-reimbursed care. When I talked about non-reimbursed were you including bad debt in yours, Ted, as well?

Mr. JOSPE. Yes. I was including what we call bad debt and charity care, which is the way that you can, I guess, in a fashion logically lump it. I would just for one brief moment respond to something that Ray just said.

Your use of the word contribution from the hospitals to this pool is an interesting word. It's sort of the same way people pay their taxes.

Mr. McGRATH. I was trying to be kind.

Mr. JOSPE. The fact of the matter is the community of not-for-profit, tax exempt hospitals in this State are taxed. The euphemistic word is assessed. The fact is taxed. And this tax which is levied against our gross receipts is put in a pool and then monies from that pool are redistributed from the estimation of the pool administrators, which is the Commissioner of Health, given to the more needy cases, so to speak. And what has evolved out of that system is a two-tiered doling out, if you will, from the pool.

For the average institution what looked like about 85 percent of your charity care initially when the whole thing was put in place to begin with, is now something closer to 30 cents on every dollar of uncompensated care that you render. You put your money in the pool and then you get back out 30 cents for every dollar you spent or didn't receive in adequate compensation.

For the second tier hospital which my institution is now, you get about 80 cents back on each dollar of bad experience that you have, but it's 80 cents on each dollar of the bad experience you had 2 years ago, not this year, not last year, not now.

And just as so many other things, when the economy begins to falter and things go poorly, that amount of uncompensated care doesn't go down, it goes up. And 2 years from now or now 2 years from before, it's vastly different than what it was or what it will

be. So that even though some small handful of hospitals can be identified as having an extraordinary problem, the response to that problem is still not adequate, and there's a vast difference between our experience and our recompense.

Mr. DOWNEY. How many employees are engaged in the processing of paperwork related to claims and regulations at Southside?

Mr. JOSPE. I think we could probably get away with a generic in this fashion something like 26 or so percent of the overall hospital expenditure profile relates to regulatory response. And that's really an all encompassing thing related to all kinds of paperwork. Some of that regulation is appropriate, is necessary, and I don't mean to imply that it's not. But if you say 26 percent, it's 26 percent of about 1,300 employees. It's a big number.

Mr. DOWNEY. Dan, what about at Good Samaritan?

Mr. WALSH. Well I think when you're talking about savings and administrative cost, I think you're talking about some savings from hospitals. But I think as Dr. Liebowitz said, you're also talking about all the administrative overhead of every insurance company that processes a form. And the administrative savings I've read about that quote a savings of 20-25 percent in savings, I think a lot of that is coming from the fact that Prudential and Travellers and Cigna and all the other insurance companies may not have to have in the future all their overhead which adds to all the costs of health care.

Mr. DOWNEY. Right.

Mr. WALSH. So the hospitals are, I think, the administrative savings in the system only a very, very small component.

Mr. DOWNEY. You think it's more on the insurance company.

Mr. WALSH. I think there's much more savings to be made in simplification that would benefit the person who goes in to pay a bill. And completing those forms is a nightmare for anyone, I don't care what your education is, it's complex, it's difficult. And simplification of forms and simplification of the system should really be moved in that direction.

Mr. DOWNEY. I realize that you have to go back and deal with doctors and insurance companies and boards of directors and hospitals. I've got some questions for you coming up, Dr. Liebowitz, I haven't forgotten you.

You're kind of waltzing around some of the things that H.R. 1300 does and does effectively. I mean we have one simple form, you know, it's we're going to have a set of rules and regulations based, hopefully, on rational judgments and experiences as to what procedures should be compensated and for what amount. We're going to eliminate a lot of the costs that you have pointed out, all three of you, as both duplicatory and unnecessary.

What is wrong with moving toward a single payer? Is it just that we have such a large system that it's difficult to go from what we have to something else or is it that you see political problems with insurance companies and doctors' associations and other providers that stand in the way of seeing us move from what is a system that you point out, Dan, has a lot of good things to it, and I'm glad you pointed them out. But in the same breath it is frightfully expensive, as Ray pointed out, and getting more expensive.

Mr. WALSH. I guess I'm concerned about, we're a vast country, 250 million people, and to make the transition in one sweeping bill could create a lot of problems. The eventual outcome might be something like the bill you described or something similar to it, that's why I talk about the concept of incremental centralization.

I firmly believe that we do have to move to simplification of a lot of the processing of paperwork that takes place in the system is simply too complex for the average person, it's too complex for the provider.

Mr. DOWNEY. And too expensive.

Mr. WALSH. And too expensive. The only debate we have is the timing of it and the extent to how quickly the total package or something of a total package should be implemented.

Mr. DOWNEY. Ted, do you want to say something?

Mr. JOSPE. We've had not the best of experiences along a similar kind of line in New York, and I think it can be responded to with three euphemisms: 1) just because I'm paranoid doesn't mean you're not after me; 2) no good deed shall go unpunished; and 3) if power corrupts than absolute power corrupts absolutely. And I think if we fold all three of those euphemisms into the philosophy and that's what I'm afraid we're going to wind up with.

It absolutely has its positive elements, its better elements. I'm very concerned about what motivates or what would continue to motivate the masters of the system. And if, in fact, it turns out that instead of being needs driven, as I suggest the system should be, it becomes budget driven, then somebody's idea of saving a dollar is going to have a disastrous affect on a very large system instantaneously.

There's no question of a doubt if you had one payer you would save one big bucket full of money in terms of administrative costs right off the bat. But there's a general belief, and I would propose to you that if you polled the folks in the audience you would see that what I'm about to say is probably generally appreciated, is that the government is kind of a scary model of an organization that does things inefficiently. People just don't believe that.

There are very significant, very major programs that the government does better probably than anybody else is going to be able to do. We're just afraid about how this works because when New York State has endeavored to do this the goals became instantaneously prostituted and we have a mess.

Mr. DOWNEY. Now, Dr. Liebowitz, you want to say something on this and I want to hear from you and then I want to ask you some questions.

Dr. LIEBOWITZ. I think we reached a very important core issue. In what I had to say during my remarks I spoke, as others have, of the potential for saving what seems to be an enormous amount of needed money by simplifying and centralizing and perhaps conceivably down the road putting in one-half the process of collecting money and paying it out.

But he who pays the piper calls the tune. And there is real concern, not just among physicians, but among sensible patients, that while truly centralized financial mechanisms may provide the vehicle for variety and innovation, indeed even more worrisome, they may remove some of the things that we value most.

Let me give two examples. One I've already given, the way the administration handled RBRVS. I believe it was Congressman Stark who said in June, and I was surprised by the drama of his words, that he thought that this was deliberate in order to poison the well. Angry physicians would lose confidence in the fairness and predictability of a centralized health care approach.

The second concern I share on this also arose this year as the consequence of *Rust v. Sullivan*. The doctor gag bill or the doctor gag rule applied initially, or in this instance, with regard to reproductive advice for women is an extendable concept. Indeed, in the decision written by the Chief Justice he said if Congress undertakes to pay for a program, it may undertake to say what those in the program can offer in the way of advice.

It doesn't take a leap of imagination to visualize a time down the road with a centralized billing and paying and decision making system in which physicians, this may seem futuristic but it occurs to me, are told which patients could not have a discussion, a discussion, of cardiac bypass surgery, kidney transplantation, hemodialysis.

So while I do not want to imply that these concerns should stop the consideration of ways to save the vast amount of money that was needed, I think there are precautions that have to be considered by Congress.

Mr. DOWNEY. And that is a very valuable point. I think that you've heard from the response of the audience that there's enormous skepticism about the government's ability to do anything right. And the problem that we face is that there is no law that suggests to us that government is inherently inefficient, and conversely there is no law that suggests that simply private industry is the most effective or the most efficient.

Obviously western European countries have come to a rapprochement, if you will, between their providers and their systems where they manage to do very much for a lot less money. Now, I'm not suggesting that the care in Germany in all instances is better than it is in America, but you don't have to worry about the things that we heard testified to before, and it's only 8 percent of GNP. Also it's true in Japan and also true in Canada.

So I think your suggestion to us is something that we have to listen to very carefully and try to deal with only because it's reflected out there in the public. I mean people say, I'm very concerned about this.

Let me ask one question before I turn this over to Ray. Ted, you cited the four current epidemics tuberculosis, syphilis, measles and AIDS. And let me ask Dr. Liebowitz to start with the answer to your question.

When I was a kid these were all considered to be under control. What in your opinion, Dr. Liebowitz, is wrong with the health care system that has allowed some of these epidemics to reemerge?

Dr. LIEBOWITZ. Well, first of all, the emergence of the AIDS virus was something unanticipated 15 years ago, and everyone knows how rapidly and how disastrously that has spread. But I think if you add to that the problems of poverty, drug addiction and use, homelessness, then the compounding can be visualized.

Syphilis is on the rise because of that combination. Tuberculosis is on the rise and becoming more dangerous from that combination. I think it's clear, it's obvious, it's almost a truism that medicine and health care cannot by themselves cure all of societal ills. And health care becomes more difficult because of those ills.

Therefore, the agenda before the American people and before Congress is not limited to health care, health care relates to the others, and I think that's why these epidemics are becoming more serious.

Mr. DOWNEY. Thank you, Doctor. Ray.

Mr. McGRATH. Thank you, Tom. As an aside, 16 years ago I voted for a bill in the New York State Legislature which did away with the blood test required before marriage for sexually transmitted diseases because there was virtually no sexually transmitted diseases at that particular point in time and it was cost beneficial any longer to have it done. I'd probably suggest that they repeal that repeal as quickly as possible.

Let me ask you this question. Understanding that somebody is going to pay for whatever health system that we have whether it's going to be in increased taxes or increased costs to employers or something, what should the responsibility in terms of that financing be for individuals?

For instance, since a lot of what puts people in doctor's offices or hospitals are diseases that can be controlled by an individual's behavior such as smoking, such as drinking, such as driving without their seat belts, do you think additional premiums or additional costs to those individuals should be levied for those people who exhibit those kinds of behaviors that jack up the cost of health care for the rest of us?

Dr. LIEBOWITZ. I think first of all, speaking as a physician, the obligation to take care of those who have become ill even through years of self abuse is clear and compelling.

Mr. McGRATH. It's undeniable.

Dr. LIEBOWITZ. All strategies, obviously, to discourage and in some cases make illegal, for example seat belts, behavior that runs up those costs and shortens life. In terms of them trying to reach the individual, it would be my opinion that the carrot would be more effective than the stick, and premium deductions for the non-smoker, for the car that is excellently equipped for safety, for the person who has avoided certain kinds of destructive behavior would be preferable to in trying to charge more, because I suspect you wouldn't collect more.

Mr. McGRATH. Perhaps not. Let me play devil's advocate for a minute. When I came to Congress we were spending \$25 billion for Medicare. This year we'll be spending \$135 billion for Medicare. And you guys can't make it on something that's increased 500 percent over the last 12 years. Why?

Obviously, people are living longer, I'll give you that. Obviously, the technological advances in MRI's, reimbursement for MRI's and CAT scans and things that weren't available 12 years ago are present today. What else?

Mr. WALSH. People are living longer. As I said in my comments, I think in some respects we are the victims, in some areas where people have access to health care, of our own success. We can do

things medically that we could not do when you initiated this program. Technology has advanced dramatically and people expect to get the best and to get what is necessary to provide appropriate treatment or diagnostic assessment.

Mr. McGRATH. How much of the increase in Medicare or the total cost of providing medical care for your hospital, or in your case, Dr. Liebowitz, as a physician, is the cost of defensive medicine as a result of high malpractice insurance claims and trying to protect your own rear end so that you're not accused of providing less than the best medical care?

Dr. LIEBOWITZ. I think there is some of that. But let me try to go to the heart of your question. Once you have adjusted for inflation and some increase in the size of the subject population, as I'm sure you would do in those two figures, there is a substantial increase that exceeds ordinary inflation.

And I think once all of the other answers are given about improved technology that comes expensively and the increasing expectation of the sophisticated population that they should have that available to them. Once you've said all that, I think there's waste in the system. To deny that, I think we'll lose credibility.

I don't think it's extraordinary, I don't think it's banner headline, I think it's there and I think, although I do not want to address too many subjects, I think that's part of the agenda to eliminate duplication. The things done twice they should be done once. The MRI, therefore, is not necessary once the CAT scan is done. I think that exists.

I would not want to see it exaggerated and I would not want to see anyone denied what is there. How much of that total accounts for, I'm not a good enough health economist to know. I believe in all the components though and I think that's part of the agenda.

Mr. McGRATH. I've often wondered why with the evolution of the practice of medicine from let's just say the X-ray to the CAT scan to the MRI, that's just over the last 10 years really. In each case every single procedure which is reimbursed by Medicare or any other third party payer assumes a portion of that reimbursement for the R&D that went into the construction of that particular apparatus.

It seems to me it would be a hell of a lot more cost beneficial if the government, assuming that this is a redeemable commodity, would say, okay, Westinghouse, okay, GE, go into a competition, design the next generation MRI or whatever it may be, and whatever it costs you to develop this, R&D and the basic research and demonstration, we're going to pay you a certain percentage of that, let's say 75 percent. But after that when you go into production, you can't charge the hospital, you can't charge the freestanding clinic, and you will not get reimbursed for the R&D portion of the total cost of the operation of that machine. I personally think that's probably a way to go, but I'm not sure how to put into effect.

And finally, let me just, if I might, for your own sake, Dr. Liebowitz, without trying to be argumentative, we had every great intention when we established the Resource Based Relative Value Scale. The idea was to shift reimbursements from the high cost of some procedures, ophthalmologists who do the transplants and thoracic surgeons down to the primary care physicians like internists,

family practitioners, general practitioners and others, understanding that it was going to be phased in operation.

Certainly mistakes were made and this whole process needed to be neutral. I don't ascribe any kind of Pete Stark scenario to the manner in which it turned out. I will tell you this though, and very interesting to me, this behavioral offset component of the update factor. You bought volume performance standards as part of the relative value scale which is simply the empirical reduction or increase in the update factor as a result of real numbers somewhere down the line. The behavioral offset was a guess for the first 3 years.

Now, we can argue what that guess ought to be. But economists tell us that the offset is real. Now, we don't know who to believe on this. The fact simply is this, that since this issue became a forefront issue in the medical community, \$7 billion that was assumed to be lost to the system was replaced into the system, and so far I believe everybody, at least on the professional level, has signed off. Now, if that is not the case, well then maybe you should come and talk to us individually. Thank you for the testimony.

Mr. DOWNEY. Let me just close not only with a thanks but one observation. Again, Dr. Liebowitz, you made the point about a single payer system and the government having so much to say, and you raised an interesting point, you came at it more from a liberal perspective, that is, the gag rule which I find abhorrent and have voted against, and think it was an enormous mistake. It was a regulation of the administration, not an act of Congress.

Don't you have, to a certain extent, this decision of what physicians can say and what physicians can do happening today with managed care programs? I mean aren't you in a way restricted on medical decisions and possible outcomes that you'd like to see by the decision of insurance companies?

Dr. LIEBOWITZ. I must tell you, Congressman Downey, I'm as concerned about that as the other. But on the one hand we're talking about the shading of advice and availability done in multiple dispersed sites versus the single controlling hand of government that all at once decide for all, but I'm concerned about both.

Mr. DOWNEY. Now, I would prefer, frankly, for the political system which is responsive to the people, to be making a lot of these decisions. You could be sure that if some regulatory agency of the government suddenly decided if we had a single payer system that physicians should do one thing and it met with the broad disapproval of the population, that you would have Ray and me jumping all over this because we would be hearing from people. I mean there is a response in a political process that is very, very valuable to health care.

Part of the process of making decisions on the final days and weeks of life, you know, do we want to emphasize hospice care as opposed to tremendously expensive medical procedures that we know don't prolong life. I don't want to leave that simply to an insurance industry. I want there to be a broader debate, a broad consciousness about these decisions that is currently now the case. I don't think any of you disagree with that idea.

Well the three of you have been excellent and we really appreciate the testimony that we've heard from you.

Thank you. We will next hear from a panel of advocates. We will try to move this process along a little faster. I know some of you who may not be familiar with congressional hearings may wonder why this is a tedious process. This is the Donahue show compared to the way committees of Congress really operate if you want to talk about tedium.

The next panel, Alice Martin, Chair, Nassau Coalition for a National Health Plan; Shirley Levy, R.N., Co-Chairperson, Suffolk Coalition for a National Health Plan; and Hugh Cleland, Long Island Progressive Coalition, and Professor of History, State University of New York at Stony Brook.

Without objection, all written statements will be put into the record.

Alice, why don't you begin.

PANEL THREE, CONSISTING OF OF ALICE A. MARTIN, CHAIR, NASSAU COALITION FOR A NATIONAL HEALTH PLAN, GREAT NECK, NY; SHIRLEY LEVY, R.N., CO-CHAIRPERSON, SUFFOLK COALITION FOR A NATIONAL HEALTH PLAN, HUNTINGTON, NY; AND HUGH CLELAND, PROFESSOR OF HISTORY, STATE UNIVERSITY OF NEW YORK AT STONY BROOK, ON BEHALF OF THE LONG ISLAND PROGRESSIVE COALITION,

STATEMENT OF ALICE A. MARTIN

Ms. MARTIN. Thank you, Tom. And I think the distinctive and very notable point about this hearing is that it is bipartisan. You are addressing a topic which is of interest to people of all political parties and that great mass of people of nonpolitical persuasion out there. What is necessary is for the people who are activists, and those of us who are on this panel would certainly characterize ourselves as that, to translate that concern to you. I don't think it's grandiose on our part to say that what we do is we speak for people who do not speak, not because they don't have the opinion, not because they haven't had the experience, but because they are a part of what we used to call the silent majority in another context. So that I hope you will hear what we have to say as coming from a broader base.

My name is Alice Martin. It's terribly, terribly tempting to not, I'll restrain myself a little bit, to not comment on the juxtaposition of those two former panels. The first was composed of people who suffered, who experienced, who were telling us their firsthand experiences. The second three, all estimable gentlemen, were speaking from a turf position, from an entrenched sense of what their own concerns were. And I think the contrast of those two was massive, and one that I certainly hope you folks will appreciate.

Good morning, and thank you, Congressman Downey and Congressman McGrath, for the privilege of being here. I made the comment that I think is very valid of this being of bipartisan concern and you noted also that you are coming from a point of view of your own committee which is concerned with seniors. I'm addressing that aspect and also the fact that I'm very senior.

I represent the Nassau Coalition for a National Health Plan, a grassroots organization with well over 40 mainstream organizations such as the Long Island Council of Churches, the Alzheimer Asso-

ciation, the Long Island Federation of Labor, AFL-CIO, and many, many others. We also number several hundred individuals in our coalition. My colleagues and I speak to thousands of Long Islanders in the course of a year and we have close contact with our sister organization, the Suffolk Coalition for a National Health Plan, also appearing here.

Before I speak on how the elderly fare under the present system, I want to stress that those of us who are over 65 are not a separate species of humanity, we're what all of you young guys over there will eventually be years from now, and the concerns that we have are concerns which all American people have and which are more acute when you become older because you have more physical concerns.

Having said that, and relying on the other speakers to deal with specifics, I still would like to focus on a few points, the two glaring flaws in Medicare, the lack of preventive care, and the lack of long term care. I know that you both, Congressmen Downey and McGrath are not only aware of these flaws but have offered legislation that would amend the Medicare Act, and that's what Congressman McGrath is calling and emphasizing as interim steps are necessary but don't let's be beguiled by interim steps. We can interim step ourselves into disaster.

The critical thing about our health care crisis is not just a health care crisis, it's the fact that it's worsening, that each year the costs go up, and that is what needs to be addressed. This is not a static situation, this is an ever worsening crisis.

So, the best example of the inadequacy of Medicare is the fact that all Americans over the age of 65, about three-quarters have supplementary insurance. 75 percent and that includes people whose income is way, way down there. Our organization had a questionnaire in which we polled people, and I did some of the interviewing in senior centers where people were living barely above a few bucks a month over and above their Social Security income and they felt that they needed to have supplementary insurance. That's disgusting in a word.

We found in the survey that women especially would sacrifice food, if necessary, to pay for the premiums of Medigap because they feared the destitution that a serious illness could cause.

When it comes to insurance for long term care, our national attitude can only be called shameful. More of us are living longer and, you know, let's not blame the victim on that, we all want to live longer. Not all of us have families or spouses to provide care, and yet we contemplate the debasing ritual of spending down to pauperdom, as the first panelist told us about, in order to enjoy the privilege of entering a nursing home. Studies showing the rapid deterioration of individuals entering nursing homes are widely known; that home health care could provide a more human and humane environment is equally known. And it's accessible only to a wealthy few or to some on Medicaid. The current private insurance offering long term care is inadequate and extremely expensive. Nine out of 10 New Yorkers have no long term care insurance.

Just a note on a recent New York State Medicaid regulation. Until now, if an institutionalized nursing home resident had to be

taken to a hospital, the nursing home held the bed for 2 weeks, and that was very important in two ways. One, it was important to the nursing home resident because they needed to have the feeling of security of going back there, and it was also important to the well being of the nursing home.

That's been cut by 50 percent and there is the menace that it is to be cut entirely. The result of that so-called economy is that hospitals will now frequently have to keep these patients longer, because you can't throw the patients out on the street, though it's come pretty close to that in some sense, at four to five times the cost to the taxpayers. Emergency rooms will be further burdened and the whole system further stressed.

Another kind of Medicaid patient is the elderly person well below the poverty line who had both Medicare and Medicaid. Theoretically, such patients are eligible to the wider span of services which Medicaid offers. The reality is that almost no private physicians accept Medicaid reimbursement, understandably since a physician is paid as little as \$11 a visit.

There's, for instance, dental coverage for Medicaid recipients. However, no dentist in Nassau County accepts Medicaid patients except those in the overburdened, fiscally threatened County Department of Health network. And I wrote that last week. Since then the cuts in the Nassau County Department of Health and the cuts in Nassau County Medical Center are such that all dentistry is threatened. Possibly what will be retained will be dentistry for very young children. At some point we middle class people have got to put ourselves in the shoes of other people.

I'd like to comment briefly on another aspect of the economic impact on the elderly: what can be identified as hidden health care costs. Now, we all know how much we pay for our deductibles, our out-of-pocket, our supplementary and so forth. What needs to be focused on as well is the costs that we don't realize, the costs that we are paying.

When there was all that talk about uncompensated care, yes, that goes back to the State. It also gets loaded onto every single hospital patient that comes into the doors. This hearing is taking place in Long Island where both counties have been plagued with trying to maintain services while not putting further tax burden on its citizens.

Those of us who pay taxes to towns, to villages, for library budgets, for school budgets, to say nothing of State and Federal taxes are paying for the whopping amounts that go into the budget of every level of government. Take a look some time, those of you who pay school taxes, on what percentage of those taxes are of that budget, that school budget which comes down to us as taxes, that horrid, horrid word, includes monies spent for coverage of school employees.

And I know that the people who will be speaking on the next panel having to do with unions will talk about the whole impact in terms of costs there. In addition, they're all paying for costs in the Medicare and Medicaid programs in addition to our own Medicare payments. We pay for health costs in most American made goods and services that we buy as the automobile industry has so dramatically shown.

Calculating these hidden expenses for individual citizens is something that is going to be coming more and more, our own coalition is working on that. Of course none of this need be. We all know that the health care crisis must be addressed. Even President Bush is said to have a plan.

All sectors of society acknowledge that things cannot go on as they are. In addition, the administration's counting of the credit solution, the tax credit solutions in the public arena for the purchase of medical insurance there are three main solutions: pay or play, managed care, and a single payer bill such as H.R. 1300, the Russo bill.

Only the latter would provide universal, comprehensive coverage and will be paid for by addressing the rising cost and will be capable of controlling cost, not adding to them beginning with the enormous saving which could be realized through the elimination of the private insurance industry.

A brief word on pay or play proposals. They do almost nothing to contain costs since they retain the role of the private insurers. If anything, they add yet another level of administrative costs. They also retain the two fatally flawed programs, Medicare and Medicaid, their general impact on the economy, continuing the linkage of employment with health care worsens the U.S. competitive stance.

As for managed care, the most recently boosted solution, this is the system where economies are made not through restraining red tape and cutting back 26 percent administrative costs that the prior panel hospital representative noted, instead it cuts costs by cutting services. Private HMO's are the hottest Wall Street item proving to be excellent money makers for Health Care USA, Humana and the other company.

For the patient, however, it limits care, sometimes by limiting laboratory tests, consultations, actual procedures deemed necessary. Physicians whose paperwork load would be increased many fold, are rewarded financially by withholding care.

Members are limited to treatment from within the system utilizing specialists from their own roster. The appeal is largely to the young and healthy who can play Russian roulette with their and their family's future health care needs. For the old it is burdensome and discriminatory.

The only answer is a bill such as Russo, H.R. 1300. It is not perfect. We are not in this life looking for perfection. It does meet the basic criteria of our coalition; it covers everyone, offers comprehensive care including long term, preventive and prescription drugs and one could spend a whole segment of time talking about what the elderly spend unreasonably on prescription drugs and it is a single payer, therefore, controlling costs.

I like to emphasize that a bill which addresses the needs of all the people supports what should be a basic tenet of our society. We cannot afford to have our Nation fragmented in the manner we increasingly see. Rich and poor, African-American and white, Hispanic and Asian, and we elderly don't want to compete with young parents seeking day care and immunizations. We want to support them.

Health care for all can help the quality of life to the inner city poor, for factory workers as well as for those who are old now and for those who will reach those not so golden years.

Advocates for the elderly, almost by definition, must be advocates for a single payer, universal comprehensive health care system.

Our coalition thanks you for considering this question and urges your support for our point of view.

Thank you.

[The prepared statement of Ms. Martin follows:]

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ALICE A. MARTIN, Chair

DONNA KASS, Co-Chair

JANET ALLEN, Sec'y.

MARK DAVIS, Treas.

STATEMENT; ALICE A. MARTIN, CHAIR NASSAU COALITION FOR A
 NATIONAL HEALTH PLAN

Good morning, and thank you for the privilege of sharing in this effort to present the impact of current health care conditions on the elderly, and to comment on reform proposals. I represent the Nassau Coalition for a National Health Plan, a grassroots organization with well over 40 mainstream organizations, from the L.I. Council of Churches to the Alzheimer Association, and the L.I. Federation of Labor, AFL-CIO. We also number several hundred individuals in our Coalition, as Associates. We educate and advocate for a single payer system. My colleagues and I speak for and to thousands of Long Islanders in the course of a year. We also have close contact with our sister organization, the Suffolk Coalition for a NHP.

Before I speak of how the elderly fare under the present system I want to stress that those of us who are over 65 are not a separate species of humankind; the conditions we face you will face; we are what you will be. If the elderly are more forthright in speaking up for necessary reforms, and in going to the polls, perhaps it's because we've learned something in the span of years the gray hair and wrinkles have taken over. And we're here today to point out that we're not greedy geezers, but rather Americans recognizing the democratic process can only work if we participate. And when it comes to health care YOU CAN COUNT ON OUR RAISING OUR VOICES. NO GROUP KNOWS THE NEED FOR HEALTH CARE REFORM IN THE FIRST HAND WAY OF THE ELDERLY.

Having said that, and relying on the other speakers to deal with specifics, I still would like to focus on a few points: the two glaring flaws in Medicare, the lack of preventive care and the lack of longterm care. I know that Congressmen Downey and McGrath are not only aware of these flaws but have offered legislation that would amend the Medicare Act. But it must be asked, why continue with band-aids, on a seriously flawed, ailing system?

The best example of the inadequacy of Medicare is the fact that of ALL Americans over the age of 65 about three-quarters have supplementary insurance. The other 25% include those on Medicaid, and those who are among the 15 to 20% of our population at or below the poverty line. We found, in a survey our organization conducted here in Nassau, that women especially would sacrifice food if necessary to pay for premiums for Medicare, because they so feared the destitution that would result if they could not pay.

Organizational Affiliates Partially:
 Alliance for Retirees; Nassau County Retirement Association; Nassau County Association of University Women, Mid-Island Branch; CSEA Nassau Retirees, #919; Coalition vs Domestic Violence; Communication Workers of America, Local 1104; Day Care Council of Nassau; Elmont Elementary Teachers (Ret.); Epilepsy Foundation of LI; Ethical Humanist Society's Social Action Comm.; Economic Opportunity Council of Nassau; Family Service Association; Gray Panthers; Health and Welfare Council of Nassau; Hempstead Hispanic Civic Assoc.; Joint Political Action Comm.; JASA; LI Sickle Cell Project; Minoia Golden Age Club; Nassau Division, National Assoc. Social Workers; National Assoc. Retired Federal Employees of LI; Nassau Senior Forum; National Council of Jewish Women; National Marlam Foundation; NY State Teacher's Pension Assoc.; Ombudservice of Nassau; Retired Educators, Great Neck Teacher's Assoc.; Unisys Sperry Retirees Council; Unitarian Universalist's Social Responsibility Comm.; Plandoms; Womanspace of Great Neck

When it comes to insurance for longterm illness, our national attitude can only be called shameful. More of us are living longer, not all have families or spouses to provide caregivers, and yet we contemplate the debasing ritual of spending down to pauperdom in order to enjoy the privilege of a nursing home. That there are studies showing the rapid deterioration of individuals entering nursing homes is widely known; that home health care could provide a more human and humane environment is equally known. And it is not accessible to all but the fortunate few, and some on Medicaid. The current private insurance offering longterm care is inadequate and extremely expensive. Nine out of ten New Yorkers have no longterm care insurance.

Just a note on a recent New York state Medicaid regulation: until now if an institutionalized nursing home resident had to be taken to a hospital, the nursing home would hold the bed for two weeks, during which time it was reimbursed for that period. That has been cut by 50%, and the fall-out from that economy is that hospitals will now often keep these patients longer - at four to five times the cost to the taxpayer, waiting rooms will be further burdened, and the whole system further stressed.

Another kind of Medicaid patient is the elderly well below the poverty line, who has both Medicare and Medicaid. Theoretically such patients are eligible to the wider span of services which Medicaid offers. The reality is that since almost no private physicians accept Medicaid re-imbursement - understandably, since a physician is paid as little as \$11 a visit - this is a hollow mockery. There is, for instance, dental coverage for Medicaid recipients. However, NO DENTIST IN NASSAU COUNTY ACCEPTS MEDICAID PATIENTS, except those who are in the over-burdened, fiscally threatened County Health Department of Health network.

Still another major problem for the elderly is the exorbitant cost of prescription drugs. The U.S. pays the world's highest prices for pharmaceuticals, as noted in the NYTimes of May 24. Americans pay 54% more on average than do Europeans for 25 commonly prescribed drugs. Parkinson patients, for instance, pay \$240 monthly for a supply of Eldepryl, a commonly prescribed drug for this sad illness; the same amount costs \$28 in Italy and \$48 in Austria. Frequently, vital prescribed drugs will be diluted, halved, or taken intermittently because to use the full dosage would mean a sacrifice of other necessities.

An economic burden which goes unrecognized has to do with hidden costs of our health care. When older people are asked what costs they bear for their health, they respond with listing their premiums, deductibles, and out-of-pocket expenses. Yet everyone pays a great deal more into the incredible \$740 Billion Americans spent in 1991. These include our share of local taxes, county taxes, federal taxes, and all the pass-along costs for made-in-the U.S. products and services. Our Coalition is working on

calculating these hidden expenses for the ordinary citizen.

Of course none of this need happen. We all know the crisis must be addressed. Even President Bush has a Plan. Interestingly enough his Chief of Staff presented the proposals to the top executives of the American Medical Association, instead of real live people who endure the inequities and misery of America's health care system.

All sectors of society acknowledge that things cannot go on as they are: In addition to the Administration's touting of tax credits for the purchase of medical insurance, there are three main solutions in the public arena: pay or play, managed care, and a single payer bill, such as H.R. 1300, the Russo Bill. Only the latter is universal, comprehensive, and can be paid for by controlling costs, not adding to them.

A brief word on pay-or-play proposals espoused by some members of Congress. These do almost nothing to contain costs, since they retain the role of the private insurers. If anything, they add yet another level of administrative expense. They also retain the two fatally flawed programs, Medicare and Medicaid. Their general impact on the economy, continuing the linkage of employment with health care, worsens the U.S.' competitive stance.

As for "managed care", the most recently boosted solution: this is a system where economies are made not through restraining red-tape, but limiting treatment. It is the corporatizing of health care. Private HMOs are the hottest Wall St. item, proving to be excellent money makers for Health Care USA, Humana, and the dozens of companies competing for the health care buck. For the patient it limits care, sometimes by limiting laboratory tests, or consultations, and with harmful effects on patients. Patients, whose paperwork load would be increased manyfold, are rewarded financially by WITHHOLDING care. Members are limited to treatment from within the system, utilizing specialists from their own roster. The appeal is largely to the young and healthy, who can play Russian Roulette with their and their families future health care needs. For the elderly, it is a burdensome and discriminating system.

The only answer is a Bill such as Russo, H.R. 1300. It is not perfect, but we are not in this life looking for perfection. It does meet the basic criteria of our coalition, it covers everyone, offers comprehensive care - with longterm and preventive and prescription drugs included - and it is a single payer.

I'd like to emphasize that a Bill which addresses the needs of ALL the people supports what should be a basic tenet of our society: we cannot afford to have our nation fragmented in the manner we see around us, rich and poor, African-American and white, Hispanic and Asian - and certainly not according to age. We elderly don't want to compete with young parents seeking day-care; we want to support them. And we know that health care for all of us can help the

quality of life for the inner city poor, for factory workers, as well as for those of us who are old now, and those of you who will reach those not-ver-often golden years.

Advocates for the elderly must, almost by definition, be advocates for a single-payer, universal, comprehensive health care system.

Thank you.

Mr. DOWNEY. Thank you, Ms. Martin.
Ms. Levy?

STATEMENT OF SHIRLEY LEVY

Ms. LEVY. I'll say good afternoon and thank Mr. Downey for inviting me to participate in this program, and thank all my fellow citizens for coming out and sharing this program on health care on this rainy day.

My name is Shirley Levy and I am the Co-Chairperson of the Suffolk County Coalition for a National Health Plan. This is a group of individual associates and about 20 organizations representing thousands of people across Suffolk County who are pulling together to work for a responsible national health care bill. We would like to go on record in support of Representative Marty Russo's bill H.R. 1300. While this bill effectively addresses the health needs of all citizens, my comments will focus on the needs of women and children.

Access to appropriate health care is a resource that is increasingly denied to women and children of all ages in our society. About 85 percent of all private health care coverage is group coverage through employment because women and children are more likely to be low wage earners employed in the service sector or in part time jobs. Women and children predominate among the underinsured or totally uninsured.

Women who work full time in their homes may have health insurance through their spouse's employment and lose this coverage through their spouse's death, divorce or increasingly through their spouse's unemployment. Lack of adequate health insurance significantly increases the percentage of income women pay for out-of-pocket medical expenses. Access to care cannot be dependent on employment, marital status, medical condition or age. Therefore, universal care for all citizens and legal aliens as provided in the Russo bill is a requirement.

Comprehensive care is also essential. Some health problems are faced by both men and women and in similar proportions, others are unique to women. In Suffolk County cancer is the second highest cause of death amongst men and women, but cancer is the number one cause of death amongst women age 35-54. Breast cancer is the leading cause of death among American women. Nassau and Suffolk County claim the regrettable distinction of having among the highest rate of occurrence in the country. 10,000 American women die yearly from uterine, cervical cancer. Heart disease is the leading cause of death for women over age 65, and for men of all ages. Black, older women have the highest rates of hypertension of any group.

Osteoporosis affects half of women over age 45 and is a leading cause of hospitalization among older women. Yet, preventative screening is not covered by many insurance company policies or completely by Medicare. The United States is 24th amongst Nations in preventing infant mortality, and in some sections of Suffolk County compares even lower to the rate of many impoverished third world countries, yet prenatal care is unavailable to many women in our county and State. Preventive care is a mounting dis-

aster. The AIDS epidemic increasingly affects women and children and requires new health care programs to be locally available.

Yet with all these unmet needs, there are fewer than 10 health care clinics across the broad expanse of more than 1200 square miles in Suffolk County. Some of these clinics open only once a week. In some there can be up to a month's wait to see a physician. The average woman today can expect to spend as many years caring for a dependent parent as she does for a dependent child. One-third of the women providing such care are in poor to fair health themselves. Even when as a last resort nursing home care is sought. Suffolk County has a projected deficit in 1993 of over 2000 beds. Some facilities which were already planned for are not being built because of the budget crunch. Dental care, eye and hearing care and prescription drugs are all services that must also be included in any adequate health care program. All of these services can be provided under Representative Russo's H.R. 1300 bill.

The Russo bill eliminates out-of-pocket expenditures. Cost sharing prevents low income people, mainly women and children, from obtaining care or else it shifts the cost that they cannot afford to them. When cost sharing is part of a plan, as it is in many of the other bills now being considered in Congress, it substantially increases the administrative cost of the program since it requires means testing. Service utilization is far better controlled by the physician or the provider who makes the decisions for ordering procedures and recommending future visits, than by the patient who is eager to follow the doctor's orders but unable to afford the cost.

The Russo Bill single payer structure eliminates administrative waste and establishes national and State health budgets that provide for efficient health spending. It eliminates that huge army of claims reviewers, processors to establish eligibility, billing clerks, collection agencies, and advertising and marketing consultants that are part of the present system of 1500 different insurance companies. H.R. 1300 also provides for equitable financing through progressive taxation sharing the cost among all citizens. Building upon the present system is like taking an aging, broken down car or an aging worn out washing machine and continuing to try to fix it when it really needs to be replaced by a new, well-designed model. Tinkering with the present system is like putting band-aids on the hemorrhaging body of this Nation's health care system.

The Select Committee on Aging, and you Mr. Downey, as its honorable chairman, are well aware of the Nation's health needs. The issue of a National Health Plan which will meet the needs of all of our citizens is of immediate and paramount importance. A single payer system such as the Russo bill, H.R. 1330, will provide funds that insure the uninsured and make adequate health care an entitlement for all of us.

We thank you for your support of national health care.

Mr. DOWNEY. Thank you, Ms. Levy. Professor Cleland?

STATEMENT OF HUGH CLELAND

Mr. CLELAND. Good morning. I am Professor Hugh Cleland of the State University of New York at Stony Brook. I'm testifying for the Long Island Progressive Coalition, a coalition of labor, environmen-

tal, religious and human and civil rights groups. We work very closely with the Nassau and Suffolk Coalitions for a National Health Plan, and I'm also a member of the Suffolk Coalition.

As I drove down here this morning through a humidity that was about the same as it is at the bottom of the Sound, and I didn't have to be here on time, and you guys did, I wonder, did you ever think, you know, I could have been a barber and worked around the corner or I could have had a little dream house or something like that or maybe Mr. McGrath can practice medicine, I suspect listening to him that he could do that. At any rate, I support the Russo bill. I want to thank Mr. Downey for his support, and I just can't wait for the day that I can thank Mr. McGrath for his support too.

We all try to say something different. And when we think of the need for better health care, we most often think of the aging. But as a university professor I can speak to the unmet needs of the young. I have often had students, particularly in evening classes, who suddenly officially withdraw from class just before the mid semester. And I begin to internalize this, what am I doing wrong, you know, what's the problem?

So I called a number of them up and I was told that they worked during the day at a job with no health insurance and they really registered for classes so they would technically be undergraduate college students and they would then be covered by their parents' insurance even though they were over 21. So each semester they registered for school and they dropped out just before they flunked out. They'll always have a student ID and they're simply doing it because they can't get health insurance.

More and more young people just entering the labor market are now hired as part time workers or as vendors. When they are hired in this way they receive no benefits. Employers often do this to reduce their costs, but as a result newer employees have no health insurance. Particularly hard hit are the graduate students, the graduate teaching assistants, the graduate laboratory assistants in our major universities. And let me just put a plug in here, MRI was not developed by Westinghouse or General Electric, it was developed by a faculty member at Stony Brook. But our scientific and technological future as a Nation depends on these young scientists. And our universities and research laboratories and libraries couldn't operate without them for a day. Many of them spend long years working on advanced degrees.

The average graduate student, according to the Department of Education, takes 6.9 years to get a Ph.D., and many of them have dependent spouses and small children. But the State University of New York and most other research universities provide little health insurance for these important and hard working employees and assistants.

A serious illness or an accident for graduate students or their dependents, often mean that they must leave school and end their studies. This is hardly a way to ensure our future competitiveness with other advanced countries where graduate students are automatically covered by health insurance because everyone is.

We hear of skilled, educated employees who could increase their productivity and the productivity of the country by changing jobs

but fear to do so because they or their spouse or children have developed a health care problem which would not be covered by the insurance plan of a new employer because the health plan would be a pre-existing condition. This break on economic mobility undermines our national competitiveness.

We find that the current health insurance crisis enormously complicates labor relations for both employers, as Mr. Leotta pointed out, and through labor unions. As the cost of health insurance soars, more and more time, energy, animosity and otherwise avoidable strifes, take place over health care benefits. In Europe, Japan or Canada the national health plan provides for health insurance without labor or management becoming involved except for the taxes both pay to support the system, taxes which the Congressional Budget Office estimates would be fair less than what companies now spend for health care insurance.

The cost of health insurance is especially difficult in the building trade where there's a great deal of unemployment, people don't work many hours, and consequently, contributions to union health plans are now so costly, that they against using union tradesmen in productive and skilled segments of the labor force.

We have terrible financial problems in the counties as everyone knows. I'm told that in the 1992 budget in Suffolk County 15 percent of the expenditures will go for health insurance for employees. Under the Russo bill that would be 7 percent. And the cost of Medicaid would be absorbed by national insurance.

People have said correctly that consumers have to alter behavior but there's certainly a relationship between behavior and primary care. The people who educate people on how to behave or not how to behave, most often are the family doctor that they know and trust. If they don't have one, they don't get that.

There's been doubts raised about the Russo bill being too centralized. The model in Canada works mostly through the provinces. It is very much decentralized. Medical professional associations are very much involved, and provides for the same decentralization.

The one State in the union where there is universal health care is Hawaii. And the figures from Hawaii are striking. First of all, they have twice as many office visits as is the average in the country and they have half as many hospitalizations. And that shows what primary care can do. The result is that their health costs are far lower than in other States.

I think that we have to approach this problem of insurance companies or other providers who are primarily interested in income, by thinking of health care not as an economic commodity but as a human right. No one would say let some company insure the rights of free speech or free press or freedom of assembly or freedom of religion for people who can afford it, and we will worry about the human rights for other people. I think if we think of this as human rights it will greatly improve our thinking on it.

The Long Island Progressive Coalition passed out votes at a number of rallies we've held on whether or not people want the Russo bill. Thank you very much.

[The prepared statement of Mr. Cleland follows:]

TESTIMONY PREPARED FOR THE HEARINGS OF THE HOUSE SUB-COMMITTEE ON
HUMAN SERVICES, JANUARY 14TH, 1992

Good Morning. I am Professor Hugh Cleland of the State University of New York at Stony Brook, and I am testifying for the Long Island Progressive Coalition, a coalition of labor, environmental, religious, and human and civil rights groups. We work very closely with the Nassau and Suffolk Coalitions for a National Health Plan. The LIPC for over a year has been doing outreach work for health care reform and in the course of that work, we have become more aware of the problems that the present health care crisis poses for the infrastructure of our country. I would like to speak to that subject.

We hear of skilled, educated employees who could increase their productivity and the productivity of the country by changing jobs, but fear to do so because they or their spouse or children have developed a health care problem which would not be covered by the insurance plan of a new employer because the health problem would be a "pre-existing condition." This brake on economic mobility undermines our national competitiveness.

We hear of potential new entrepreneurs and employers, trying to start new businesses, who have great difficulty getting health insurance for their employees. This is true because they are starting out small, and the rates for small groups are higher. It is also a hindrance on new job development because new employers just getting started are often short of funds, and the extra cost of health insurance, and the time and effort spent in getting coverage, discourages new enterprise.

When we think of the need for better health care, we most often think of the aging. But as a University professor, I can speak to the unmet needs of the young. I have often had students, particularly in evening classes, who suddenly officially withdraw from class just before mid semester. When I called up some of these students to ask why they had dropped out, I was told that they really registered for classes because they had no health insurance, but as long as they were technically undergraduate college students, they

were covered by their parents insurance, even though they were over 21. So each semester they registered for classes, and then withdrew.

More and more young people just entering the labor market are now hired as "part time "workers. When they are hired in this way, they receive no benefits. Employers often do this to reduce their costs, but as a result newer employees have no health insurance.

Particularly hard hit are the graduate students in our major universities. Our scientific and technological future as a nation depends on them, and our universities and research laboratories could not operate without them. Many of them spend long years working on advanced degrees and many of them have dependent spouses and small children. But they have no health insurance. Universities today cannot afford to buy health insurance for their graduate teaching assistants, and graduate students are not covered by their parents insurance. A serious illness or accident for graduate students or their dependents often means that they must leave school and end their studies. This is hardly a way to insure our future competitiveness with other advanced countries, where graduate students are automatically covered by health insurance because everyone is.

Let me give you an example of how the anxious pursuit of health coverage skews social behavior. The Chamber of Commerce in one of our Long Island villages secured health insurance for its members. When this became known, dozens of new people rushed to join the Chamber of Commerce to get health insurance. The policy was then cancelled.

As the cost of health insurance through existing insurers like Blue Cross and Blue Shield has gone up, groups such as local governments or school districts have begun to insure themselves, and in doing so, they get lower rates--which seems like good management. But because groups of teachers or local government employees do not include a fair share of elderly or sick people, Blue Cross has to raise its rates, because it has a disproportionate share of expensive subscribers. This encourages other groups to move to self insurance or to commercial carriers, and the whole self defeating cycle continues. And as plans multiply, and companies vie with each other to sell coverage to this or that group or sub group, the

enormously expensive and inefficient bureaucracy of health insurance sales staffs, claims reviewers, lawyers, check writers, actuaries, and so on, proliferates, eating up the dollars we spend supposedly on health care.

We find that the current health insurance crisis enormously complicates labor relations for both employers and labor unions. As the cost of health insurance soars, more and more time, energy, animosity, and otherwise avoidable strikes take place over health care benefits. In Europe, Japan, or Canada, the national health care plan provides for health insurance, without labor or management becoming involved, except for the taxes both pay to support the system--taxes which the Congressional Budget Office estimates would be less than what companies now spend for health care insurance. The costs of health insurance is especially difficult in the building trades, where union health care plans are now so costly as to militate against using union tradesmen, one of the most productive and skilled segments of the labor force.

A large part of our present health expenditures go for megatons of paper work., for health providers, patients, and multiple levels of insurers. A retired employee of the State University has as her primary coverage Medicare. After a deductible is met, her bills are sent to Medicare. In due course, she is reimbursed for part of her bill. She can then send the remainder of the charge to a secondary insurer acting on behalf of the state. After another deductible is met, she is reimbursed for part of the remaining cost. But it costs \$15 for the state appointed insurance company to process her claim, even if it is not paid. So the employee may well be sending in a claim for \$12--which she truly needs, but it costs the state \$27 to pay her. The need for streamlining and simplification is obvious.

We find that as employers are solicited by health insurance salesmen to switch from one carrier to another in order to save costs, employers find that they get somewhat better rates if they do not hire women or older workers, because those groups statistically have somewhat higher medical treatment costs. But as a nation, we need the economic contributions of these workers, and they as citizens should receive health care.

Mr. DOWNEY. Thank you. One of the things, one of the reasons I wanted to do this with Congressman McGrath, this, as you know, is part of a national program, today was part of a national program that my party is hosting around the country to highlight this issue. And one of the things, aside from the partisan concerns that I have, is that we are not going to do this national health insurance system, the Russo bill, which I really want to see happen, without presidential support. If President Bush is re-elected, we're going to have to work with him to get this done.

And the political action that you provide to all of us is very important. And Congressman McGrath and I have worked on a variety of issues ranging from welfare reform to day care, enhancing day care, and now on health insurance. So we are trying to do something that is normally not done around here and that is, to the extent that partisanship can be put aside and we recognize health care as a human right, as a basic right of Americans, that's how we want people to see it.

And I don't think that there's any doubt, at least not in my mind, from what you've testified here to day that these issues are critically important to you, critically important to both our constituencies. And how we resolve them will be part of the political dimension in the next couple of months. I hope that we have a vigorous debate on this issue.

But I want to add my words to those of yours, Professor Cleland, that this is something in my mind that is profoundly important and is a matter of basic fundamental rights. That's how people view it. Whether the political system appreciates that at this point, I'm not quite sure. Ray, did you want to say something?

Mr. McGRATH. Yes. Let me just thank the panel for their contribution today. I told my wife that I've seen more of Alice Martin than I do of her. But it's always nice to see her.

Let me just say this. Whether you're for the Russo bill or against it or for some other way of doing it or whatever, it seems to me that for the first time that I can remember everybody is on the same page in terms of the objectives that we seek to achieve. We want universal coverage and access, we want cost containment, we want to reduce the paperwork burden and whatever, and we want to maintain the quality of care that we seek to achieve for our constituents.

One of the things that concerns me about the effort though, is being oversold to a large extent. I have people who come up to me and ask me about a national health program in which they articulate, of course, that they will pay for nothing and they will get everything from eyeglasses to shoes to whatever, band-aids.

And it seems to me that whatever system that we come up with, including a system like this, which would be perhaps regionally distributive in terms the administrative burden, certainly you're not suggesting that Canada, who has 25 million people in 10 provinces running a health care program, that map can be overlaid on the United States where the Federal Government, 50 States, serving 250 million people, and spread it 10 times, and it's going to cover the whole system in the manner in which it works in Canada.

Somebody said today that the system that we're going to come up with will be uniquely American, and I really truly believe that, it's

not going to be the Canadian system because frankly, if I had to vote on the Canadian system now I wouldn't. I don't believe the care in the Canadian system on the acute level is anywhere near adequate to what the expectation is in the United States.

And then, of course, having said all of that and agreed on all the objectives, one of the things that I am constantly reminded of is somebody is going to pay for this. The Russo bill has a very large in the personal income tax to do this along with some other things.

But I remember another bill, going back just a few years ago, it was called Catastrophic Health Insurance Bill. And I remember everybody was for that bill until we asked everybody to share equally in the payment of it, and then nobody was for it.

I'll never forget this, this is a very short story. The AARP was for it, Jim Roosevelt's group was for it, everybody was for it, and then, of course, the electorate revolted and they were against it. I was invited to come in to speak to the AARP in my home town, Valley Stream. I expected another group of maybe 50 people to come in. And I walked into the Elks Lodge where they had their meeting and there was 550 people in the room. I knew I was in trouble right away.

So I asked my staff if there was a blackboard in the place, it was a bingo hall, and there sure was. So I went down and I enumerated all of the things that the new bill provided. Instead of having 60 days coverage in the hospital, it was 365 days. There was a piece in that bill which provided for mammographies every year, colorectal screenings, there was a very nice piece in there which would have provided that you didn't have to spend down in order to get on Medicaid. There was a thing called spousal impoverishment, and a whole list of other things.

And I went down this list, and I said to the audience, anybody got any problems so far? No. How many people out there, even though I'm on the Ways and Means Committee I'm not the IRS, how many people out there made \$10,000 or less above and beyond their Social Security? Half the people raised their hand in the room.

I said, okay, I'll tell you what, there are two ways to pay your income tax, if you're married you file a joint return, if you're an individual, you file an individual return. I'm going to compute for you what your premium would be for all of these benefits that you agreed were a good thing.

And sure enough I took the \$10,000, I subtracted the personal exemption, it was \$2,000 at the time, I subtracted the standard deduction and that was \$4,000 for an individual. And we got down to around the \$4,000 figure and along the way I was making intentional mistakes, so that my school teacher in the audience would say, Ray, you made a mistake on that one.

So then that was your adjusted gross income, applied the 15 percent rate, and you came up with a tax liability, individual tax liability. The conversion factor for the new premium was \$22.50 for every \$150 of liability. So I divided the 150 into the tax liability, it came out to be about two and a half, and then multiplied it by \$22.50 and it came out to be something like \$48 for an individual making \$10,000 or less above their Social Security for the new benefits. I said, anybody got any trouble with that?

Then we did it for a joint return. Two personal exemptions from 10,000, a \$6,000 standard deduction. Their tax liability was zero. So it was zero twice because there were two people. They paid nothing for the new benefits for filing a joint return. And I did it for the \$15,000 class and it came out \$75 for individual, \$45 twice for the joint return. And I did it at 20,000 and at 25,000 and 30.

Finally there was a \$800 cap on all of this, couldn't pay more than \$800 for the same benefits that people were paying \$2,200 for on their Medigap insurance. Finally had \$45,000 of income above their Social Security before you had to pay the \$800 as a new premium. I said, anybody in the room make \$45,000 a year above their Social Security? There was about six guys smoking a cigar in the back of the room. I said well about 10 women up here want to meet you.

That was the point. I couldn't convince my own mother that this was a good deal for her even though she would pay \$45 or \$50 a year for this benefit. My point is simply this, that whatever we decide, let's be honest with the people in terms of what it's going to cost them so that we won't go through the same scenario again, that they will know what they're getting for their money and that they are willing to pay for what they are getting. And that's all that I am seeking in all of these deliberations that I am going through within my own district and throughout the State.

Mr. DOWNEY. Thank you, Ray. Alice, do you want to make one quick comment?

Ms. MARTIN. Yes, I'm sure we all want to respond to that. Personally you folks did not have the complete lock on your position on catastrophic. I belong to an organization that vociferously pointed out the flaws in catastrophic.

There was a basic flaw, and it is the reason why we should not be comparing that with trying to move towards a national health plan such as Russo. I can understand your point of view because you got burned, so you feel that up close and personal. But step back and look at it.

Those costs of the catastrophic bill was a tax on the elderly, it was a graduated tax but not completely because it stopped at a certain point.

Mr. DOWNEY. \$800.

Ms. MARTIN. So that it was not truly a progressive tax. What the Russo bill does is address the entire population and the entire population of people who are within the tax framework will be paying for it and it will be a reasonably progressive tax.

And also, you're not taking into account the question that I raised very briefly, and I think some of the other people may have touched on, that there are so many other costs besides the direct health care cost that we don't see. And it's an education problem. Of course we've got to show people. I mean tax is the dirtiest word, much dirtier than sex, for God sake. We've got to show people that they will be paying less, not more, and they will be paying for which everyone is covered.

Mr. DOWNEY. Did you want to say something, Ms. Levy?

Ms. LEVY. I would like to be personal for a moment. Last year my husband and I decided we needed to include long term care in our policies and went about exploring a number of different compa-

nies. We finally settled on one, and we were fortunate enough to pass the physical that went along with that process.

Those policies for the two of us costs us now about \$4,000 a year, which we are struggling with but we feel they're important, rather than the \$72,000 a year which we couldn't afford if we had to go into a nursing home.

My husband recently figured out, given Russo bill financing process, what it would cost us if we had the Russo bill. Our family would save about \$2,000 a year if the Russo bill were in effect now, and we are not in a high tax bracket.

I would like to mention that the Russo bill is financed very equitably through taxation, personal income tax which is now 15 percent, 28 percent and 32 percent, the 15 percent rate stays the same, the 28 percent rate goes up a small 2 percent to 30 percent, the 30 percent rate goes up to 32 percent, and those of us in the audience who make over \$200,000 a year that goes up 4 percent.

I think that, as Alice said, the catastrophic bill really can't be compared because the financing on it was totally inequitable. Mr. Russo does provide for additional financing on Medicare costs because of the long term care coverage. But even given that, most middle income Americans would save, I'm sure, at least \$2,000 a year which we figured out we could save.

Mr. CLELAND. There's no free lunch and you're going to have to pay taxes for it. If you're not going to pay deductibles, you're not going to pay for the mega tons of paperwork that Dr. Liebowitz talked about earlier. So as the saying used to be, we'll eliminate the middle man, we'll have to pay taxes.

Mr. DOWNEY. I want to thank you very much for your testimony.

The Committee will next hear from its last panel. Nicholas Ezzo, Director of Retiree Affairs, Branch 6000, of the National Association of Letter Carriers; William Warner, Executive Director, Labor, Education and Service Organization, President, Health and Welfare Council of Nassau County; and David Rothenberg, President-Elect, Long Island Council of Senior Citizens, who will be accompanied by Virginia Gridley who is its present President.

Mr. Ezzo, if you will begin with your testimony or summary of your statement.

PANEL FOUR, CONSISING OF NICHOLAS EZZO, DIRECTOR OF RETIREE AFFAIRS, BRANCH 6000, NATIONAL ASSOCIATION OF LETTER CARRIERS; WILLIAM F. WARNER, EXECUTIVE DIRECTOR, LABOR, EDUCATION AND COMMUNITY SERVICE AGENCY, LONG ISLAND FEDERATION OF LABOR; AND DAVID S. ROTHENBERG, PRESIDENT-ELECT, LONG ISLAND COUNCIL OF SENIOR CITIZENS; ACCOMPANIED BY VIRGINIA GRIDLEY, PRESIDENT

STATEMENT OF NICHOLAS EZZO

Mr. Ezzo. Congressman Downey, I'd like to thank you for inviting me to this hearing and I represent Branch 6000, National Association of Letter Carriers.

I'd like to direct your attention to the hardship placed on the retired letter carriers concerning the health premium costs. A recent ruling by the Officer of Personnel Management makes it mandato-

ry for all the retirees to enroll in Medicare Part B in order to keep their current National Association of Letter Carrier health plan.

This ruling will make many of our older carriers, 70 and 80 years old, premiums double under Medicare Part B because of the 10 percent penalty for every year past 65 that they did not enroll in Medicare.

For Part A the cost would triple. Our retirees can no longer afford the fragmented health system now in effect in the United States. We, along with the American public, labor and corporate America, are looking toward Congress for a national health plan to benefit all Americans.

Thank you.

[The prepared statement of Mr. Ezzo follows:]

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JAN-13-92 MON 11:00 CHRISTOFFERS

P. 02
P. 02

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Joe Rivers, Int. V.P.
Don Proitano, 2nd V.P.
Walter Barton, Recd. Sec.
Tom Keyes, Fin. Sec.
Larry Carter, Treasurer
Dave Diamond, Dir. of City Del.
Fred Nuzzi, Area Rep.
John Buck, Spl. at Arms

Long Island Merged Branch 6000
National Association of Letter Carriers

AFL-CIO



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January 13, 1992

Beginning January 1, 1992, retirees enrolled in the National Association of Letter Carriers Health Benefits Plan must be enrolled in both parts of Medicare (A & B) in order to receive 100% coverage of approved medical costs.

To comply with this new ruling the retirees will have to pay a \$31.80 monthly premium for part "B" Medicare Coverage Plus a 10% penalty for each 12 Month Period they could have been enrolled. The ones who have to enroll in part "A" along with part "B" will have an added \$177.00 monthly premium plus the 10% penalty. Added to this expense is the \$113.21 monthly premium for coverage under the N.A.L.C. Health Benefits Plan.

This will have a catastrophic effect on many of our retirees because their costs will now double. Many will have to forgo the Medicare Coverage and this will mean a much greater out of pocket expense for medical costs not covered by the N.A.L.C. Health Benefits Plan.

The cost of Health Care in the Metropolitan area keeps going higher & higher, many doctors will not accept Medicare as Medicaid patients because of the fees. Surgeon fees are higher here than the rest of the Country. The cost of nursing homes on Long Island are double the national average, a Nursing Home located in Babylon, N.Y. just raised their fee to \$185.00 a day for a semi-private room, average \$5,700 a month. Supplemental medical insurance coverage for Long Island keeps going up every year with less & less coverage.

Retirees can no longer afford the high costs of Health Care. We are looking to you for some relief with the passage of a Universal Health plan to cover all Americans.

Nick Ezzo
Nick Ezzo
Dir. of Retirees
Branch 6000, N. A. L. C.

Mr. DOWNEY. Thank you, Mr. Ezzo. Mr. Warner?

STATEMENT OF WILLIAM F. WARNER

Mr. WARNER. Good afternoon Tom and Ray. My name is Bill Warner. I'm president of the board of directors of the Health and Welfare Council of Nassau County, a private not-for-profit planning and advocacy agency that's composed of over 400 public and private human service agencies and organizations providing services to the vulnerable in Nassau County.

I'm President and Executive Director of the Labor Education and Community Service Agency of the Long Island Federation of Labor. The Labor Federation represents over 100,000 working men and women on Long Island and their families. I have also been involved in the health planning activities for over 20 years serving on the board of the Nassau-Suffolk Health Systems Agency and its predecessor Comprehensive Health Planning.

We are delighted that you've taken the time to hear our concerns about what is fast becoming the number one concern of our members, their health security. I'm sure I don't have to remind you of the long and bitter NYNEX strike over health benefits a little more than a year ago. Indeed, maintaining health insurance coverage has become the number one concern of the unions when negotiating new contracts with their employers.

Speaking with the recently unemployed Pan American workers, next to security a job with health benefits, the major concern that they express is what are they going to do about health insurance coverage. We at the Labor Agency provide services for recently displaced workers. We heard the same concerns about health care from laid off workers from Eastern, AIL, Grumman, Times Square Stores, Fairchild-Republic and other firms that have had reductions in their work force.

The Long Island economy suffered a prerecession blow as more than 15,000 Long Island NYNEX employees struck for more than 4 months in a bitter strike about employee contributions to health plans.

The volatile situation surrounding the explosion in health insurance care has created bizarre situations. Persons are fearful of changing jobs because a new job may not have health insurance or may not cover a preexisting condition.

The present employer-based health insurance system is geared to full time employees. We've heard stories of firms who'd rather employ two part time workers rather than one full time worker to avoid paying health benefits. In fact, the fastest and only area in which employment is growing on Long Island is in part time employment which is up 75 percent in the last year.

Long Island hospitals report to us the hidden costs of recession. The emergency rooms are overflowing with persons in need of routine medical care who use the emergency room for primary medical care because they do not have health insurance. The not-for-profit hospitals on Long Island reported an accumulated operating deficit of \$110 million, caused in large part by providing health care to uninsured individuals, while New York State reports spend-

ing over \$400 million from the bad debt and charity pool to cover uninsured health care in the State's hospitals.

While residents of Long Island and New York State feel the ever increasing burden of larger governmental deficits and program cuts, these same local governmental bodies feel the pressure as providers of health care through Medicaid, public hospitals and clinics. They've also impacted as employers trying to pay for health coverage for their employees.

We in the labor movement are also concerned that the high cost of health insurance can make these businesses who do provide good health benefits to their employees uncompetitive with those who provide minimum or no benefits.

As you know, the president of Chrysler Motors likes to point out that cars he builds in the United States cost from \$600 to \$800 more in health insurance costs than the cars made in Europe, Japan or Canada because these countries have a national health program.

Therefore, it is time for the United States to join the rest of the industrialized world and establish a national health plan. We join the thousands of other individuals and organizations in demanding a change in the way the business of health is undertaken. We offer the following principles as the basis for the necessary restructuring of the system:

First, coverage should be universal. All Americans should be covered in the same program. It should not matter where you live. All residents of the United States should be entitled to the same minimum benefits.

Second, coverage should be comprehensive. A national health plan should include preventive care, prescription drugs, long term care at home and in nursing homes, as well as the full range of medically necessary care. If long term care is not included as part of a national health care plan, it will have to be provided for in some manner.

Third, the plan should provide a free choice of providers. Patients and doctors are not satisfied with having insurance companies choosing their health care providers. Long Islanders are reporting that some of their primary care providers are even reluctant to make referrals to specialists that they do not know, and just present their patient with a list supplied by the insurance company.

Fourth, there should be no out-of-pocket costs such as deductibles and co-payments which tend only to create barriers to care and add to overhead costs when providers try to collect these relatively small payments.

Fifth, the program should operate under a single payer system for efficiency, reduction in paperwork and overhead, and for cost control.

For these reasons we believe the Universal Health Care Act of 1991, as introduced by Representative Russo, comes closest to addressing the health care crisis as seen from Long Island.

I'm sure that you do not underestimate the nature and scope of this problem. In the face of this crisis Americans are expressing their powerlessness. They tell us they don't know whether they'll ever see the day that such an equitable system will be put in place.

They tell us that they believe the powerful forces of the health care industry will never permit such justice to occur and that public leaders don't have the courage to do what's necessary.

On behalf of the many families and individuals at risk on Long Island, I thank you for opening the door to constructive discussions on national health care. I thank you for giving us the opportunity to raise our voices in hopes of resolving this national disgrace.

[The prepared statement of Mr. Warner follows:]

Statement of William F. Warner
Executive Director
of the Labor Education and Community Service Agency
of the Long Island Federation of Labor
and President of the Board of Directors of the
Health and Welfare Council of Nassau County, Inc.

Good Morning Congressmen Downey and McGrath. My name is Bill Warner and I am the Executive Director of the Labor Education and Community Service Agency of the Long Island Federation of Labor. I am also the President of the Board of the Health and Welfare Council of Nassau County. The Labor Federation represents over 100,000 working men and women on Long Island and their families. The Health and Welfare Council is made up of 400 public and private human service agencies and organizations providing services to the vulnerable of Nassau County. I have also been involved in health planning activities for over 20 years serving on the Board of the Nassau-Suffolk Health Systems Agency and its predecessor the Comprehensive Health Planning Council.

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dislocated workers. We heard the same concerns about health care from Eastern, AIL, Grumman, Time Square Stores, Fairchild-Republic and other firms that have had reductions in their work force.

Long Island business, labor and government leaders continually report that they are financially hemorrhaging because of the exorbitant costs of for health insurance. In turn employers pass on the increased costs to employees in the form of co-payments and deductibles. Deductibles, which until recent years would be for \$100-\$250 per individual now can exceed \$1000 per family per year. This is not health care insurance - it is catastrophe insurance! The Long Island economy suffered a pre-recession blow as more than 15,000 Long Island NYNEX employees struck for more than 4 months in a bitter strike about employee contribution to the health plan.

The volatile situation surrounding the explosion in health insurance care has created bizarre situations. Persons are fearful of changing jobs, because the new job may not have health insurance or may not cover a preexisting condition.

The present employer based health insurance system is geared toward full time employees. We have heard stories of firms who would rather employ two part time workers rather than one full time worker to avoid paying health benefits. In fact, the fastest, and only, area in which employment is growing on Long Island is in part time employment, which is up 75% in the last year.

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need of routine medical care who use the emergency room for primary medical care because they do not have health insurance. The not-for-profit hospitals on Long Island reported an accumulated operating deficit of \$110 Million Dollars, caused in large part by providing health care to uninsured individuals, while New York State reports spending over \$400 million dollars from the Bad Debt and Charity pool to cover uninsured health care in the states hospitals.

While residents of Long Island and New York State feel the ever increasing burden of larger governmental deficits and program cuts, these same local governmental bodies feel the pressure as providers of health care through Medicaid, public hospitals and clinics. They are also impacted as employers trying to pay for health coverage for their employees.

The Medicaid program, which was instituted as a health care for the poor, has become the principle provider of long term care for the middle class elderly. Today, almost 60% of Nassau's 100,000 poor and near-poor under age 65 are not participating in the Medicaid program. Simultaneously, Medicaid is the prime provider of Long Term Care for those of any income. Of Nassau's total Medicaid population of 19,991, 6,231 (or almost 1/3) are in Long Term Care institutions and another 2,234 are elderly with personal care aides. While middle income seniors make financial plans to shelter income and assets and become eligible for Medicaid should they have to enter a nursing home while State Officials and legislators reduce needed care for the poor to cut the costs of Medicaid.

Medicaid expenditures in Nassau County have increased from \$295,882,925 in 1987 to a projected 590,593,000 for 1992 or a 99.6% increase in just five years. In 1991 Nassau County spent over half a BILLION dollars on Medicaid.

Finally, not for profit institutions, which play an ever increasingly significant role in the provision of basic services in local communities, are being crushed by excessive health insurance costs.

Discussions with its Agency Executive's Task Force reveals that the Heath and Welfare Council's experience in this field is typical of the 300 plus not-for-profits in Nassau County.

Health insurance costs for the Council have risen from \$137.02 per month for family coverage in 1981 to 497.50 per month in 1991 (a 263% increase) in spite of an increase in co-payments and deductibles. Many small not-for-profits human service agencies can not afford to provide health insurance for employees, or for their family members. Salaries in non-profit organizations tend to be lower so that employees can not afford to purchase on own.

We in the labor movement are also concerned that the high costs of health insurance can make those businesses who do provide good health benefits to their employees uncompetitive with those who provide minimum or no benefits. The President of Chrysler Motors likes to point out that the cars he builds in the United States cost from \$600 to \$800 more in health insurance costs than the cars made in Europe, Japan or Canada because those

countries have a national health program.

Therefore, it is time for the United States to join the rest of the industrialized world and establish a national health plan. we join with thousands of other individuals and organizations in demanding a change in the way the "business of health" is undertaken. We offer the following principles as the basis for the necessary restructuring of the system:

First, coverage should be universal. All Americans should be covered in the same program. It should not matter where you live, all residents of the United States should be entitled to the same minimum benefits.

Second, coverage should be comprehensive. A national health plan should include preventive care, prescription drugs, and Long Term Care at home and in nursing homes as well as the full range of medically necessary care. If long term care is not included as part of a National Health Care plan it will have to be provided for in some manner.

Third, the plan should provide a free choice of providers. Patients and doctors are not satisfied with having insurance companies choosing their health care providers. Long Islanders are reporting that some of their primary care providers are even reluctant to make referrals to specialists that they do not know, and just present their patients with a list supplied by the insurance company.

Fourth, there should be no out of pocket costs such as deductibles and co-payments which tend only to create barriers to care and add to overhead costs when providers try to collect

these relatively small payments.

Fifth, the program should operate under a single payer system for efficiency, reduction in paperwork and overhead, and for cost control.

For these reasons we believe that the Universal Health Care Act of 1991 as introduced by Representative Russo comes closest to addressing the health care crisis as seen from Long Island.

I am sure that you do not underestimate the nature and scope of this problem. In the face of this crisis Americans are expressing their powerlessness. They tell us that they don't think that they'll ever see the day that such an equitable system will be put in place. They tell us that they believe the powerful forces of the health care industry will never permit such justice to occur and that public leaders don't have the courage to do what is necessary. On behalf of the many families and individuals at risk on Long Island I thank you for opening the door to constructive discussions on national health care.

I thank you for giving us the opportunity to raise our voices in hopes of resolving this national disgrace.

THE HEALTH AND WELFARE COUNCIL OF NASSAU COUNTY, INC.
773 Fulton Avenue, Uniondale New York 11553

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Health Issues Fact Sheet #3 November 1991

CHANGES IN MEDICAID EXPENDITURES IN NASSAU COUNTY 1987-1992

	1987	1992	Change	% Change
SNF/ICF	154,345,135	271,270,000	117,024,865	+ 75.8%
Hospitals	76,028,035	150,858,000	74,829,965	+ 98.4%
Personal Care	34,359,295	98,250,000	63,890,705	+195.9%
Pharmacy	11,177,380	22,557,000	11,379,620	+101.8%
Dr.'s & Dents	7,408,624	18,732,000	11,323,376	+152.8%
Transportation	4,264,820	12,941,000	8,676,180	+203.4%
All Other	8,299,136	15,885,000	7,585,864	+ 91.4%
TOTAL	295,882,425	590,593,000	294,710,575	99.6%
NASSAU COUNTY SHARE	53,433,661	113,256,722	59,823,061	111.9%

SOURCE: Nassau County Department of Social Services

Mr. DOWNEY. Thank you, Mr. Warner. Mr. Rothenberg?

STATEMENT OF DAVID S. ROTHENBERG

Mr. ROTHENBERG. I want to thank both of you for coming here. I also want to say that I represent the Long Island Council of Senior Citizens. Mrs. Gridley is the President and I'm the President-Elect. I want to say to you that we represent many, many groups in our organization. We have AARP, we have the National Council of Senior Citizens, New York State Council of Senior Citizens, CSEA, most of the teacher's unions, the Electrical Workers Union, ILGWU, and the Young At Heart Commack Y.

We are the only Long Island group, senior group, that endorses candidates. And for your information, we endorsed both of you last time, so I hope you will help us out this time.

Health care in the United States is not working. America leads the world in health spending but trails in the quality of health. Of the 22 leading industrial nations, we suffer the highest rate of infant mortality and rank 20th of 22 in child mortality. At the same time we rank first in per capita health spending. Entirely too much money is being spent for too little in return in health care; 37-50 million Americans are not insured and there are many more who are underinsured; 38 percent of the poor and 35 percent of the near poor are in this group. Of the employed, 14 percent are not insured; 12.2 million children have no insurance; 38 percent of the students over 18 years of age have no insurance coverage; the elderly pay more than 50 percent of their medical bills out-of-pocket, and spend 18 percent of their income for health care; 20 million Americans with insufficient insurance would be bankrupted by a major illness; 5 million young women have insurance that does not cover obstetric care and there are 2 million people in New York State who do not have insurance.

One of the problems of health care is exorbitant fees charged by the medical providers. There are now \$400 fees for annual exams, and \$100 charges for filling a single small cavity. Hospitals first question is not how you are, but do you have hospitalization insurance.

Children of the poor are seen at clinics. In many cases, a different doctor attends the child at each visit. Many times prior records are overlooked and a child is given medicine that counteracts a previous doctor's prescription. This is costly, and more important, injurious to the patient.

Increasingly more doctors are eliminating care of their Medicaid patients and are reluctant to accept Medicare assignment as full payment for services rendered.

The Long Island Council of Senior Citizens was very active in securing the passage of the mandatory Medicare assignment bill in New York State. This was a step in the right direction, but we need an intergenerational law.

Obviously, health insurance companies are aware that universal health care has become a prime issue. It is most amazing that these companies are suddenly advertising profusely on television since universal health care became a front runner on the American agenda.

The risk factor is being employed by many insurance companies making it virtually impossible to secure health insurance with pre-existing conditions. Only companies that insure municipalities, county, and State workers are required to accept all people regardless of risk factors. A pre-existing condition should never disqualify a person or family from obtaining health insurance coverage.

The private companies which eliminate at risk clients are able to keep premiums at a minimum. Insurers of public employees have seen their premiums rise by 67 percent. The Long Island Coalition for Senior Citizens has asked the New York State Commissioner of Insurance to investigate and rectify this unfair practice.

Now, let us look at the pharmaceutical people. Another example of rising health costs is the fees charged by pharmaceutical manufacturing companies in this country. It is common knowledge that many companies charge foreign nations less than they charge American pharmacy stores. A commercial wholesaler of drugs stated that, "It is cheaper to get drugs from England that are manufactured in the United States than it is to buy directly from United States manufacturers."

During the last several years the Long Island Council of Senior Citizens has fought the escalation of prescription drug prices. We have asked New York State Assemblyman Paul Harenberg, Chairman of the Committee on Aging, to investigate manufacturers of prescription drugs. In a letter sent to the Long Island Council of Senior Citizens, Assemblyman Harenberg mentions a hearing of the United States Senate Special Committee on Aging. The report states that in the 1980's drug prices rose 152 percent, three times faster than the inflation rate of all medical costs combined.

And in conclusion, the Long Island Council of Senior Citizens believes that the salvation of the health crisis in the United States is universal health care. Skyrocketing health care costs are bankrupting government, businesses, and consumers.

In order to compete, small and large corporations must pay health insurance that is reasonable. Competition is a product of democracy. If our businesses are to compete they must not be exploited by health insurance companies.

The Long Island Council of Senior Citizens opposes any bill that keeps in place health insurance companies that takes 30 cents of every dollar for administrative costs.

An example of savings, the health insurance practice of two hospitals, one in Toronto, one in Boston were compared, about the same size. The Toronto hospital has one person working on health insurance, while the Boston hospital has 45 people.

The Long Island Council of Senior Citizens supports a universal health bill that includes the following: One, a single payer system that is a publicly financed program, eliminates deductibles and co-payments, and takes the place of Medicare and Medicaid. Two, we support long term care and say to you people, any bill without this provision is not acceptable. Three, choice of provider. The consumer must have a choice of doctors, hospitals or any provider, and that the law includes dental care, prescription drugs, home health service, hospice care, mental health service.

The Long Island Council of Senior Citizens has endorsed the Russo Bill, H.R. 1300. However, there are areas that we'd like to

see changed. One, the mental health portion should upgrade the number of days of care. Two, we have a problem with our seniors, they do not like you to fool around with Social Security. And we say to you that the tax of 85 percent on Social Security, which is an unfair burden on one segment of the population. It is suggested that a tax on income would be fairer.

Passing a universal health bill is one of the top priorities for all our citizens. And we expect it in 1992.

Thank you very much.

Mr. DOWNEY. Thank you. You've given us all a lot to think about. As Ray and I were just going over some of the statistics for expenditures for Suffolk County on Medicaid, for instance, at a point that you all alluded to.

In Suffolk County the 1992 projected cost of Medicaid is \$631 million. That's in Suffolk County. Of that the County's share, the County's share which is financed out of the property tax or the sales tax or the fees, is \$158 million.

So we could say to the people of Suffolk County, the people of Nassau County that with a national health insurance system in one felt swoop one of the biggest burdens of property tax, other than, of course, the school system, would be eliminated, and this particular system would be more rationalized than it currently is.

I want to thank you very much.

Mr. ROTHENBERG. I think Virginia wants to say something.

Mr. DOWNEY. Oh, I'm sorry. Ms. Gridley, did you want to say something? Go ahead.

STATEMENT OF VIRGINIA GRIDLEY

Ms. GRIDLEY. I am Virginia Gridley and I am president of the Coalition of Retired Teacher Chapters both Nassau and Suffolk Counties as well as President of the Long Island Council, and Dave and I are about to exchange those seats.

I'm going to be like an early Roman, I'm going to take time to be very brief. I just have a couple of comments I would like to make. First of all, I thank you for this wonderful invitation. I want to congratulate the people out there for your endurance.

There's been mention today about employer-based health insurance. I think you ought to know that many people are held hostage in the jobs that they have right now. I am acquainted with a young man in a family who had a wonderful job opportunity offered to him, planned to take it, found he couldn't because in the new company his family would have been denied health insurance because a young son of theirs, 8 years old, has a cancer, Leukemia, and therefore, it was a pre-existing condition and he couldn't accept the job because of his health insurance.

We wonder sometimes who does pay for all these benefits. Well we have to keep in mind that every time we go shopping we are probably assisting some company to pay for its health insurance for its employees. I believe if you buy a new car \$800 of that cost goes for health insurance for the automobile workers.

If you buy a toaster, a loaf of bread, whatever you purchase, a portion of that goes for the health insurance of the people working for that company. So no matter where we turn we are paying for

health insurance, except who's collecting for the uninsured and the unemployed, they don't have a product to sell.

I think we should keep in mind that we have some examples of universal health care in our country and that would be the military who have their health insurance. My husband was 4 years in the second World War, I had a son who did his tour of duty in Vietnam, I have a nurse, she's here in the audience, who was 2 years a Air Force nurse in the Vietnam years. These are good examples of universal health care. And I would say, Why not for all of us?

Medicare is expanding, is including more people, but our Medicare costs, premiums taken out of our Social Security is several hundred dollars a year. We are still faced with the deductible for Medicare and co-payments, and usually it means a trip to the drug store in addition to that.

About mental health, it would be great mental health for everybody in this country if we didn't have to worry about our rising health costs particularly for the elderly. I think long term care hangs over us like a shadow.

So for the mental health of all Americans I say let's get America back with the rest of the civilized world, let's have a universal health care, H.R. 1300 if possible, or as close to that as is possible, and let's do it now.

Mr. DOWNEY. Thank you.

Mr. McGRATH. I don't believe you're a senior citizen, David. I've got to tell you I'll be 50 years old. I have an 8 month old son. I can't conceive of myself of being a senior citizen.

Along with Tom I want to thank you for your contribution for waiting so long here and then giving us the benefit of your thoughts on the system. As I said to the previous panel, I think frankly, that we're all on the same page in terms of what we want to accomplish, the question is the means to the end.

And we very much appreciate the fact that you were waiting so long. And, Nick, your little particular problem, in the event that something doesn't happen quickly with this system with your retired postal workers, Tom and I have co-sponsored a bill, as probably your president Joe LaPlata has told you, that would rectify this particular situation, that is specifically directed towards Federal retirees. So hopefully, we'll be able to give you some solutions to that problem in a hurry.

But once again, thanks for coming today and we appreciate very much your contribution.

Mr. DOWNEY. Let me add my thanks to this last panel, as well as all of you who have stayed so long and so patiently, and to John and Moya for putting this hearing together, my very capable staff. Thank you very much.

[Whereupon, AT 1:10 p.m. the hearing was adjourned.]

APPENDIX

From the New York Times, January 4, 1992

A Growing U.S. Affliction: Worthless Health Policies

By BARRY MEIER

About a year ago, Camille Ewing survived a grueling \$200,000 operation to replace his diseased heart. But he suffered one unforeseen complication: His health insurance turned out to be worthless because the plan collapsed, and he was stuck with the bills.

Mr. Ewing and his family have since been sued by Stanford University Hospital. They recently lost their home in Santa Barbara, Calif. Over 10 months, the Ewings' health coverage was shifted to two other plans. Both of them also collapsed.

"What has happened is inconceivable to me," said Mr. Ewing, a 48-year-old marketing executive who retired in 1989 because of health problems. "We're in the process of losing everything."

As the nation's health insurance crisis deepens, it is breeding a new problem, the growing sale of group health policies that prove worthless because of fraud or mismanagement. From 1988 to 1990, more than 400,000 people were victimized by dozens of problem insurance plans, according to the General Accounting Office, the Congressional investigative agency. Many like the Ewings now face ruinous bills. And others who developed serious illnesses while covered by plans that collapsed can no longer get insurance.

"Affordable medical insurance is drying up in this country while phony health insurance schemes are spreading like a cancer," said Dan Morales, the Texas Attorney General.

Federal and state investigators said a substantial number of

Insurance Mirage

A special report.

these plans appeared to be pyramid schemes that collected millions in premiums from unsuspecting employers and individuals, then collapsed in a year or so when claims started to flood in. In other cases, the plans fail because they are underfunded or poorly managed.

Currently, the Labor Department has 34 criminal investigations under way involving health insurance programs; in 1988, it had none. The Justice Department also recently formed a unit to investigate insurance fraud, and several states, including Texas and Florida, have started cracking down on the schemes.

Even Doctors Are Fooled

Brokers and agents, eager for commissions, have often acknowledged that they sold policies they knew little about. Sophisticated consumers, including accountants, businessmen and even some doctors, have bought problem policies because they were initially backed by leading insurers or marketed by unscrupulous entrepreneurs to appear so.

One insurance provider, Cap Staffing Inc. of Charlotte, N.C., used hospital insurance cards from the Travelers Insurance Company. But Travelers merely processed claims; Cap Staffing alone stood behind the plan. Its collapse left more than 5,000 people with \$1.9 million in unpaid

Continued on Page 46, Column 1

claims. Six men were indicted last year on Federal fraud charges in connection with this scheme.

Once caught in this insurance netherworld, thousands of consumers like the Ewings, many of them desperately ill, have been shifted by salesmen from one failed plan to another through group associations the salesmen control.

The rash of problem insurance comes at a time when 34.7 million Americans have no health insurance, according to researchers at Harvard Medical School. Many insurers no longer sell policies to small employers and professional groups. And some that do have raised their rates 25 percent annually for the last three years.

States are the principal regulators of insurance. But some problem plans fall into categories that are regulated only by some states. Others, including plans sponsored by unions, are exempted from state control altogether by the Employee Retirement Income Security Act. As a result, many of these plans are unregulated and rare, if ever, audited.

The harm to consumers is often devastating when such plans fail because traditional state guarantee funds do not step in. Charles Alexander of Duncanville, Tex., and his wife now face more than \$180,000 in medical bills following the March collapse of Miller Leasing, a Dallas company that provided health insurance to small companies.

"This has taken us from the upper-middle-class segment of society and put us in the upper-poverty segment," said Mr. Alexander, who sells custom homes. "I'm 62 years old and I don't see any way of us getting back again."

The problems of the Ewings and others offer a look into this troubled world. It is based on dozens of interviews with Federal and state regulators, fraud investigators and consumers, as well court papers drawn from private litigation, civil lawsuits and criminal inquiries in 10 states.

A Costly Bargain

Plan's Promises Don't Materialize

In February 1990, Camille Ewing and his wife, Doris, had health insurance. But they needed more. In September 1989, Mr. Ewing underwent a four-way heart bypass surgery and Stanford University doctors told him that he needed a heart transplant. Though their \$550-a-month policy from Blue Shield of California covered 80 percent of their medical costs, their share of the transplant and related expenses would be more than \$50,000.

A chance call from an insurance agent to a Santa Barbara gift shop owned by Mr. Ewing's mother held promise. The agent described a \$700-a-month group plan from Empire Blue Cross and Blue Shield of New York that covered bills fully. To qualify, however, the Ewings had to join an organization called Consolidated Local Union 867 of Jericho, L.I.

The Ewings decided to take a chance on the plan. They kept their old policy for one month until Empire started accepting their medical bills. But in August 1990, Empire suddenly stopped paying claims under the Consolidated plan for medical bills incurred after April 1.

The trouble was not Mr. Ewing's deteriorating health. Instead, Empire terminated the contract and sued the health plan, contending that it owed more than \$5 million in premiums.

For Consolidated's 10,000 members, Empire's action was a shock. Many, like the Ewings, were not typical union members, but accountants, small-business men and others attracted by the chance to buy Empire Blue Cross insurance. Some could not get coverage elsewhere because of high cost or existing illnesses.

"Our old insurer had just stopped writing insurance, and the other plans we looked at cost a fortune," said Karl Wickstrom, a magazine publisher in Miami.

Few Consolidated members knew about the organization's unusual history and activities. It was founded in July 1988 by William S. Loeb, a union organizer who in the 1970's had been imprisoned on perjury charges. Consolidated barely resembled a union, and devoted more energy to its insurance plan rather than contract talks. It represented employees of a Long Island insurance agency, but also used that agency to market its health plan through independent agents nationwide.

Even before Empire's action, officials in Florida and Texas warned the insurer that Consolidated was signing up members outside New York State, the only place where Empire is licensed to sell insurance.

Consolidated officials, who have since countersued Empire for breach of contract, initially said the health coverage would continue. But within weeks of Empire's action, claim payments dried to a trickle. Today, Consolidated members face more than \$6 million in unpaid medical bills.

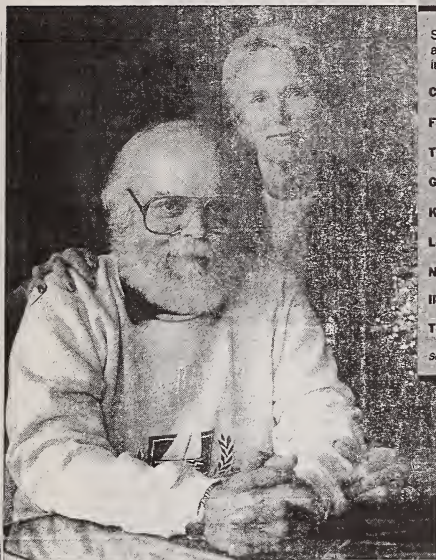
Mr. Loeb, among others, is the subject of a Federal fraud investigation in connection with the health fund's failure, said several Labor Department officials who spoke only if not identified. In a brief telephone interview, he denied any wrongdoing and referred further questions to his lawyer, who did not return several calls.

After Consolidated stopped paying claims, some members like Mr. Wickstrom found new insurers. But one of his employees, Janice Soffin, still has \$40,000 in unpaid medical bills from intestinal surgery.

The Ewings and many Consolidated members had no options. By August 1990, Mr. Ewing was living in Palo Alto near Stanford, awaiting a heart donor. His health was grave and his monthly heart medication alone cost \$1,500. So the Ewings, to keep their policy from lapsing, kept paying their \$700 monthly premiums in the hope that their coverage would be restored.

"You can't just pull the plug," Ms. Ewing said.

The New York Times



Burt Bartholomew for The New York Times

Camille Ewing and his wife, Doris, lost their home recently after Mr. Ewing's health insurance was found to be worthless and they were stuck with the bills for his heart surgery.

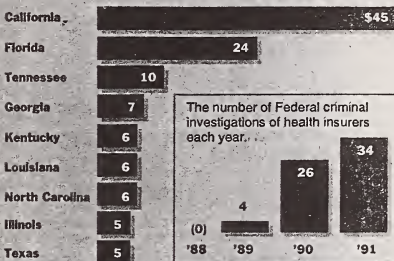


Susan Greenwood for The New York Times

Karl Wickstrom, a magazine publisher in Miami, found a new health insurer after Consolidated Local Union 867 stopped paying claims but one of his employees, Janice Soffin, at left, now faces \$40,000 in unpaid medical bills from intestinal surgery.

Insurers That Don't Pay Up

States reporting the most unpaid claims by multiple-employer welfare associations, which provide insurance for groups of employers or individuals. Figures are for 1988-90, in millions of dollars.



Sources: General Accounting Office (claims); Labor Department (investigations)

How to Check Insurer Health

Federal and state insurance regulators advise consumers to determine the soundness of any health plan before they buy it.

Call the state insurance department to find out if a plan is licensed in that state and if it contributes to a state guarantee fund. Such funds can protect consumers from unpaid claims should an insurer fail. Also, ask state regulators what they know about the insurer and its underwriter or if they are seeing many complaints about unpaid claims.

Since most problem insurers tend to fail in the first 18 months, it may also be helpful to look for an insurer that has been in business for three years or more. Although a new insurer may be able to provide good coverage, it does not have a record to examine.

Also, if a small insurer contends that its policies are backed by a large insurance company, call the larger company and have its officials explain the relationship and how much protection it offers.

A Legal Tangle

Confusing Series Of Rapid Shifts

Consolidated had reached the Ewings through a complex network of insurance brokers, agents and marketers. And in August 1990, Diversified Health Concepts, a company in Scottsdale, Ariz., that had marketed the union plan in Western states, notified the Ewings that their policy had been switched to a new insurer.

For the Ewings, the change offered a ray of hope. But the new insurer, the American Business Trust in San Ramon, Calif., collapsed about five months later, said Jan Nemmert, an investigator with the California Department of Insurance. It had existed for barely a year and attracted more than 15,000 members who are faced with over \$4 million in unpaid claims, Ms. Nemmert said.

The American Business Trust was technically known as a multiple-employer welfare arrangement. Many such plans are legitimate, helping groups of small businesses buy the sort of insurance only larger businesses can purchase. But in recent years, dozens of these plans have collapsed as a result of mismanagement or fraud.

The cause of the American Business Trust's collapse is the subject of several state investigations and numerous lawsuits. Its promoters had contended that Lloyd's of London, the British syndicate of insurers, had agreed through an American broker to underwrite it. The British insurers deny that any coverage was ever issued, said Richard Wuert, one of their lawyers.

Such legal wrangling is cold comfort to the American Business Trust's stranded members, many of whom were shifted into the plan from other failed plans by insurance salesmen. One member, Ronald Yando, now has \$40,000 in unpaid medical claims from a heart attack.

"When you go to an agent you expect to get something for your money besides bills," said Mr. Yando, who owns an automotive repair garage near Utica, N.Y. Other victims included members of the Academy of Medicine of Cincinnati, a group of 500 medical professionals and their families, said Shawn McCormick, a lawyer who represents some of them.

By early December 1990, the Ewings' medical bills had grown to more than \$40,000. Doctors at Stanford University Hospital had given Mr. Ewing just a month to live and he needed 80 nitroglycerine pills daily to keep his heart pumping. "I couldn't walk from the couch to the door," he said.

Ms. Ewing had to fight the couple's insurance problems alone. Once in a while, a small claim was paid, she said. But her attempts to have any big bills paid led her into a bewildering world of agents, brokers, billing agencies and claims administrators.

Phone calls were bounced from one company to another, she said. And some of the companies, which sometimes shared offices, changed their names so quickly that new letterheads were simply pasted over old ones, she added.

"It was like a nightmare," she said. "You didn't know where things began or ended."

A Big Loophole

Officials Say They Are Stymied

The same regulatory loopholes that fail to prevent the sale of worthless insurance also mean that thousands of consumers like the Ewings rarely have redress. When Ms. Ewing complained about Consolidated to California officials, they referred her to regulators in New York, where the union is based. When she contacted them, New York officials said they could not do anything because the union was Federally regulated.

Officials often can do little when plans like Consolidated or the American Business Trust fail. They are not covered by state guarantee funds. Legal actions against fund operators also rarely succeed.

"I get calls all the time from people who have been left stranded by these kind of plans," said Peter Winn, a special assistant attorney general in Texas. "There is nothing I can do and it makes me angry and frustrated."

But the Ewings' insurance ordeal was still not over. Last January, just weeks after Stanford surgeons replaced Mr. Ewing's heart with that of a 25-year-old man killed in a motorcycle accident, the Ewings were notified that their insurance had been switched once again.

Their new insurer was known as the B.A. Trust. It was operated by Raymond Anthony Huelefeld, the president of Benefits Administrators, a claims service in Fort Mitchell, Ky., that is now defunct. In May, Mr. Huelefeld wrote Stanford officials, stating that because the Ewings' coverage was retroactive, the new trust would pay for Mr. Ewing's transplant, which cost some \$200,000.

That never happened. A few weeks later, the trust collapsed, leaving thousands of members with more than \$8 million in unpaid medical bills, said Andrew Heiglein, an investigator with the California Department of Insurance. B.A. Trust was underwritten by the Winston-Hill Assurance Company of the British West Indies, which has no license to sell insurance in the United States, several regulators said.

Mr. Huelefeld is now the subject of several Federal and state investigations. In recent years, the 37-year-old businessman has been involved with several failed plans, said Robert Roberts, an enforcement officer with the Kentucky Department of Insurance. "We are still finding more of them all the time," he said.

In an interview, Mr. Huelefeld denied any wrongdoing in the collapse of any insurance plan. In the case of the B.A. Trust, Mr. Huelefeld also said that he had warned state regulators and policyholders that the plan was failing. "We notified every state in writing and plan participants that there was a problem with claim payments," he said.

By July, the Ewings stopped paying their \$700 premium. But time, and their cash, had already run out. That month, they defaulted on their mortgage and lost their home of 15 years. They also sued Empire Blue Cross and Blue Shield, as well as brokers and marketers connected with the Consolidated plan, said Robert L. Brace, their lawyer. Their lawsuit is pending.

Taxpayers are now picking up some of the family's bills. Recently, California officials classified Mr. Ewing as disabled, which made the family eligible for Medi-Cal, the state's public health assistance program. It has agreed to pay for Mr. Ewing's transplant operation but will have claims on any funds the Ewings recover in their lawsuit.

Many victims of worthless insurance plans feel betrayed by the government. "It is a shabby con game," said Mr. Wickstrom, the publisher in Miami.

Some Action

States Seeking To Curb Abuses

Along with an increasing number of Federal fraud investigations, some state efforts are under way to curb problem insurance plans. Several states, including Florida and Texas, have warned insurance agents that they may be held liable for selling plans that later prove worthless. Several states that have not regulated multiple-employer trusts are moving to do so.

This month, the Senate Permanent Subcommittee on Investigations, which has held hearings on problem insurance for two years, will issue a report recommending new Federal and state laws to curb abuses, said a staff member who spoke only if not identified.

Strong Federal or state action is by no means certain. This fall, California officials proposed emergency regulations that would have effectively prohibited all unlicensed insurers from operating there. But those emergency rules were rejected by a state administrative judge for procedural reasons.

In the meantime, insurance salesmen have placed more than 5,000 people who once belonged to the failed B.A. Trust into three other unregulated plans, said Ms. Nemmert, the California official. "We don't have a way to kill this," Ms. Nemmert said. "It is heartbreaking. It is really tragic."

Last month, a Federal judge in Manhattan shut down Consolidated's health insurance fund. As a result, members may never get paid for their claims.

Mr. Loeb, who resigned from the union last December, recently founded another labor organization, the National Council of Allied Employees in Glenhead, L.I., that is offering health insurance, Labor Department investigators said.

The Ewings' insurance situation is still clouded. Most of their doctors do not accept Medi-Cal. Without any insurance, new bills are being added to the old ones. Also, in two years, Ms. Ewing's coverage, under Medi-Cal regulations, will end when her youngest daughter turns 21.

"What is going to happen down the road?" Mr. Ewing said.

It's just frightening to wonder what is going to happen in the future."

HEALTH CARE FACTS

The United States: The Most Expensive Health Care In the World

- * The United States spends more than any other industrialized nation on health care.
- * Only twenty-five years ago, health spending consumed only 5.8% of GNP, not much higher than in most other developed nations. Now, in first place, our health care costs are over 12% of GNP.
- * Not surprisingly, a recent poll shows that the majority of Americans cite the high costs of health care as the number one problem confronting our health system. (NBC/WSJ 6/91)

Skyrocketing Costs For Working Families

- * The United States also leads industrialized nations in health care cost per person. In 1989, the U.S. spent \$2,354 per capita on health care. That's 40% higher than health care costs per capita in Canada, almost double the amount in West Germany and more than double the amount in Japan.
- * By the year 2000, health care costs will rise to \$5,513 per person -- a 443% increase from 1980.**
- * Families will experience a 512% increase in out-of-pocket health care costs between 1980 and 2000, from \$63 billion to \$386 billion -- not counting employee share of health insurance premiums.**
(* source: Families USA, Rising Health Costs In America, 1990.)

Uninsured: The FACTS

- * Our health system is capable of providing some of the best care in the world yet all too many Americans are excluded from vital health services.
- * According to the Pepper Commission, 15% of our nation is without any form of health insurance coverage.
- * No family, regardless of income, can be confident that it is not more than one job's loss, one job change, or one serious illness away from joining the ranks of the uninsured.

- Some 30 million Americans are uninsured. At some time over a two year period more than 60 million Americans will be uninsured.
- The vast majority of the uninsured have ties to the work force. In 1989, more than 85% of the uninsured lived in a family headed by an employed worker.**
- Many of the uninsured are young. In 1989, over a quarter of the 18-24 year olds in this country were uninsured, and more than 28% of the uninsured were children.**
(** source: Employee Benefit Research Institute, 4/90)

The Republican Answer

- The Reagan/Bush White Houses have relied on the competitive pressures of the market place to restrain health costs. This policy has led successive Administrations to cut health care funding for those who are unable to afford it and those who need it the most.
- Every Reagan/Bush budget submitted in the 1980s proposed drastic cuts in Medicare. In last year's budget talks, the Bush Administration attempted to pillage the Medicare system by proposing to cut the program by \$90 billion. (OMB, 1990)
- But every year the Republicans attempted drastic cuts in Medicare, Democrats in Congress were successful in scaling them back.
- In 1988, George Bush made a campaign promise to 'mount a comprehensive effort to reduce the cost...of health care in America.' He has yet to advance any proposals, big or small, to control costs. (Bush position paper, WPOST 9/26/91)
- The President says he favors health reform. But, Americans see through George Bush - 62% disapprove of the way he is handling the health care crisis. (CBS/NYT, 9/91)
- Americans trust Democrats to lead this country through the health care crisis. By a 2:1 margin, Americans feel Democrats are more likely to develop a plan for affordable health care and to improve the health care system. (CBS/NYT 9/25/91)

CRITICAL CONDITION: CURRENT HEALTH CARE SYSTEM

Coverage Under the System

☐ **Americans without Coverage**

34 million Americans have no health insurance.

- 23 million are employees and their dependents.

- 11 million are low-income persons.

60 million Americans do not have coverage at some time over a two year period.

☐ **Employer-based Coverage**

150 million employees and their dependents are covered by employer-based plans.

☐ **Medicaid Coverage**

25 million low income people are covered by Medicaid programs.

Costs under the System

☐ **Escalating Insurance Costs**

Private insurance premiums are increasing at a rate of 15% a year.

At this rate, individual insurance premiums will almost double by 1997.

☐ **Growing Costs to Employers**

Employer contributions for health insurance now average 11% of payroll.

Employer contributions projected to increase to 19% of payroll in 1997.

☐ **No Coordinated Cost Containment**

There are currently multiple health care payment systems without coordinated cost containment.

	<u>1993</u>	<u>1997</u>
☐ Federal Costs	\$235 billion	\$330 billion
Employer Costs	\$235 billion	\$355 billion
Individual Costs (excluding premiums)	\$180 billion	\$240 billion

SOLUTION A: MEDICARE FOR ALL HEALTH CARE

☐ **Medicare-like Benefits**

Would provide Medicare-like benefits, as well as maternal, well-child and prevention benefits, with a single deductible (\$250 individual, \$500 family).

Would place limits on out-of-pocket expenses (\$2,500 individual, \$3,000 family).

Would not cover eyeglasses, prescription drugs, or long-term care.

☐ **Universal Coverage**

All permanent residents of the United States would be covered by a single public plan.

☐ **Cost Containment**

Cost containment would gradually limit the growth in total health care payments to the rate of increase in the GNP.

☐ **Medicare-like Administration**

Administered like Medicare by private insurers acting as intermediaries.

☐ **Low-income Coverage Without Deductibles**

Would cover all low-income individuals for comprehensive benefits without deductibles or co-insurance.

☐ **Reimbursement for Providers**

Provider payments would be based on Medicare hospital and physician reimbursement rates.

☐ **Supplemental Benefits**

Private insurers would offer Medigap-type supplemental benefits.

SOLUTION B: EMPLOYER-BASED HEALTH CARE (PAY OR PLAY)

☐ **Public/Private Coverage by Employer**

All employers would provide health care coverage for employees and their dependents through private insurance or a public program.

Employers who choose not to offer insurance would contribute 9% of payroll to the public program.

☐ **Medicare-like Benefits**

Would provide Medicare-like benefits, as well as maternal, well-child and prevention benefits, with a single deductible (\$250 individual, \$500 family).

Would place limits on out-of-pocket expenses (\$2,500 individual, \$3,000 family).

Would not cover eyeglasses, prescription drugs, or long-term care.

☐ **Cost Containment**

Cost containment would gradually limit the growth in total health care payments to the rate of increase in the GNP.

☐ **Reimbursement to Providers**

Provider payments would be based on Medicare hospital and physician reimbursement fees.

☐ **Phase-in**

Phased in over time. Employees and their dependents would be covered by:

Employers with over 100 workers	1993
Employers with over 25 workers	1995
All Employers	1997

SOLUTION C: FULLY PUBLIC, SINGLE-PAYOR HEALTH CARE

- ☐ **Comprehensive Benefits**
Out-of-pocket costs to individuals, totaling \$151 billion in 1991, would be eliminated.

Comprehensive benefits would include prescription drugs and long-term care without deductibles or co-insurance.
- ☐ **Controlling Doctor Costs**
Physician payments would be based on a national fee schedule like Medicare physician reimbursement rates.
- ☐ **Pre-set Hospital Payments**
Hospital payments would be based on global budgets set annually in advance.
- ☐ **Cost Containment**
Cost containment would be based on annual budgets created at the state and national levels.

National health care expenditures could not grow faster than the GNP.
- ☐ **Universal Coverage**
Would cover all Americans.
- ☐ **Federal/State Administration**
Administered by state governments under federal guidance.

EDITORIALS

Universal Access to Health Care in America: A Moral and Medical Imperative

I am not an advocate for frequent changes in laws and constitutions, but laws and institutions must go hand in hand with the progress of the human mind. As that becomes more developed, more enlightened, as new discoveries are made, new truths discovered and manners and opinions change, with the change of circumstances, institutions must advance also to keep pace with the times. We might as well require a man to wear still the coat which fitted when a boy as civilized society to remain ever under the regimen of their barbarous ancestors.

—Thomas Jefferson (1)

With the twentieth century drawing to a close, internal medicine has the rare opportunity to lead the way in reforming our nation's health care system. As leaders of the American College of Physicians, we believe we must not let this opportunity pass. The growing needs of our patients and colleagues demand that we use all of our energies and resources to develop a better system, a system designed to improve the health of our nation in the twenty-first century. Patchwork reform is not enough; simple solutions will not suffice. Our problems are deep, complex, and growing more urgent daily. Solutions for these problems must address the underlying weaknesses in the current system that have so overburdened our patients, our profession, and the American society. To this end we are dedicating our efforts.

In 1932, the Committee on the Costs of Medical Care, a privately funded group that had completed a five-year study of health care in the United States, wrote: "The quality of medical care is an index of a civilization" (2). In the six decades since this statement, there has been a remarkable evolution in diagnosis and treatment and in the care of patients. Today, "care" is no longer enough; patients now expect, and physicians try very hard for, "cure," often to the detriment of caring as it was known in the 1930s and 40s.

Sixty years ago patients expected little and demanded less. Everyone was essentially uninsured. Patients who could afford to pay doctors and hospitals did so, and those who could not were cared for as "charity cases." Physicians donated their time and talent; hospitals were cheap and supported largely by philanthropy; expensive technology was almost nonexistent. Paternalism was both rampant and acceptable.

By the 1970s all major, industrialized nations except one—ours—had developed some nationwide system to ensure that every citizen had access to appropriate health care. In the United States, federal, state, and local programs were devised in response to changing political

pressures to address some health care needs of particular groups. The system relied primarily on private sources of insurance for the best of the population and to provide insurance for services not covered by public programs. Consequently, today we have a combination of disparate programs designed to finance or provide health care services directly for merchant marines, veterans, elderly persons, very poor persons, military personnel and their dependents, native Americans, migrant workers, and persons living in medically underserved areas. These public sector programs now account for 42% of the nation's total annual spending for health care.

Yet we still have well over 30 million persons without private or public health care coverage who must either pay for their care out of their own pockets, receive treatment as indigents, or go without. About 32% of the uncovered are children; 55% are employed adults; 40% are generally in low-paying jobs. When these persons come to hospitals, the cost of their care is passed on to patients who are insured, resulting ultimately in higher insurance premiums for everyone who pays for health insurance. As pointed out by Reemary Stevens (3), the United States has "a de facto national health service, expressed through its hospitals, although Americans are unwilling to recognize the fact and indeed go to enormous lengths to deny it. As a result we have high costs without concomitant social benefits."

The problem of providing universal access to health care cries out for medical leadership. If physicians fail to contribute to the solution of the problem, we will have only ourselves to blame if no solution is devised without us. For too long "organized medicine" has been only *against*, not *for* change.

The College believes that physicians now have a unique opportunity to participate in determining the future of health care for all Americans. Toward this end, the College analyzed the facts and statistics regarding who is and is not insured, developed criteria for evaluating present and future proposals for change, examined certain types of proposals for improving access, and preliminarily measured these suggestions against our criteria. In the past three years, we have held over a hundred meetings on the topic of improving access to health care for all of our citizens. These meetings have involved thousands of physician and staff hours by the Health and Public Policy Committee and four of its subcommittees. Discussion and debate have occurred within the Board of Regents, the Board of Governors (a group of member-elected leaders), and at regional membership meetings of ACP chapters across the country.

The topic was also a prominent part of our 1988 and 1989 Annual Session programs, where over 1000 internists expressed their views in questions and comments and on evaluation forms.

The views expressed by members during these processes convinced the College that major systems reform is needed. Our current, haphazard non-system not only leaves millions of persons without adequate access to health care, it is costly and inefficient. Tremendous administrative expenses are incurred in recording, billing, processing, reviewing, and auditing claims. Marketing health insurance policies, maintaining financial reserves, and providing corporate profits add to these costs. It is estimated that from 20% to 23% of total national health care spending can be attributed to administrative costs.

The current situation is intolerable for patients, their families, and physicians. Our members are becoming increasingly frustrated by unwarranted intrusions into clinical decision making; by the paperwork and administrative time and expense involved in responding to requirements of government and other third-party payers; by the rising costs of office practice, including the costs of professional liability insurance; and by cost-containment actions that increasingly restrict physicians' ability to provide appropriate care. The message heard throughout the country is that physicians are beleaguered and angry; good patient care is under siege. Solutions to the access problem must address the "hassle factor," reduce administrative costs and burdens, and permit physicians to provide their patients with appropriate care.

Consequently, we have come to two basic conclusions. First, major reforms are necessary. A comprehensive and coordinated program to assure access on a nationwide basis is essential. Second, piecemeal approaches have superficial political appeal and, given their capacity to ameliorate certain intolerable conditions, may be acceptable in the short term. However, short-term solutions carry the tremendous risk of simply placing band-aids on the problem. Approaches that merely build upon the present system, with its enormous administrative requirements, excessive administrative costs, and increasing intrusiveness into medical practice, will not alleviate the problems now confronting physicians and their patients daily; they may even compound them. In the longer term, new and innovative alternatives will be necessary, including some form of a nationwide financing mechanism to assure access.

In the 1840s, Alexis de Tocqueville wrote, "The early stages of national existence are the only periods at which it is possible to make legislation strictly logical; and when we perceive a nation in the enjoyment of this advantage [as America was in the 1840s] we should not hastily conclude that it is wise, but remember that it is young" (4). America is no longer young. It is now difficult for us to make our legislation strictly logical. Yet we believe that the time has come to develop a program that assures health care for all Americans.

We are in the middle of a health care revolution that is fueled by untethered technology, runaway costs, and unreasonable expectations from patients, families, and their physicians. The College seeks to help lead our nation to a better and more equitable health care system. The ACP position paper that appears in its entirety

in this issue of *Annals of Internal Medicine* details the criteria we have identified for development of a better system (5).

We recognize that our statements may be controversial, but we urge careful reading and thoughtful analysis. We anticipate cries from some that we are advocating "socialized medicine" or that we are "selling out" medicine. What we advocate is a good internist's customary openness to consider all the options. We have made a diagnosis; we propose proceeding with careful consideration of alternative treatment plans. We must reaffirm the sanctity of humankind, the primacy of the patient, and the importance of good health for all our citizens, not just those who can afford it.

The American College of Physicians joins the debate on access to health care after much thoughtful discussion. We have concluded that nothing short of universal access to a level of basic health care will be fair in the long run. How we achieve that goal and the best mechanism required have yet to be determined and must engage all concerned citizens. We have identified the principal elements that will be needed for a uniquely American system. We believe that a nation can develop a program that is fair and equitable for all. With Jefferson we believe we must "keep pace with the times." To us the times call for a national health policy, not short-term, patchwork reform.

As physicians, each of us knows that something must be done and done soon. The debate continues. The nation waits.

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Access to Health Care

American College of Physicians*

Executive Summary

The American College of Physicians believes that there is an increasingly urgent need to address a growing national problem, that of many Americans lacking access to health care. Spiraling increases in health care costs are reducing access to health services, especially for those without health insurance protection or the financial means to pay. Cost containment actions are increasingly undermining the basic infrastructure on which delivery of services depends—facilities and personnel. Further, many of these cost containment actions are eroding the ability of physicians to provide optimum care for their patients.

Problems Faced by Patients and Physicians in the Present System

Problem: Inadequate Access to Health Care

Lack of an adequate financing system to assure access to needed health care and lack of facilities and personnel contribute to the medical complications, unjustifiable pain and suffering, and expense that can result from failure to obtain timely diagnosis and treatment. Lack of an adequate financing system jeopardizes the nation's health care delivery system, as the cost burden of uncompensated care increases.

Problem: Inadequate Health Insurance Protection

"Health insurance," as used in this paper, is defined broadly to include private health insurance, public health benefit programs, and "insurance" protection through self-insured plans provided by many large employers and prepaid health plans, including health maintenance organizations. More than 205 million Americans, 86% of the civilian population, have some form of health insurance (1). Approximately 181 million persons

have private health insurance, and approximately 136 million of them obtain their insurance coverage through employment-related plans. More than 33 million persons are covered by Medicare, and about 24 million are covered by Medicaid (2). Other public health benefit programs, including those administered by the Department of Veterans Affairs (VA), the Public Health Service, and the Department of Defense, provide access to health care services for specific qualifying groups. However, health insurance coverage is neither uniform nor equitable.

Whereas many persons have overlapping and duplicative coverage, others have insufficient coverage or no protection at all. There are roughly 31 to 37 million Americans without any form of public or private health insurance. Another 50 million Americans are underinsured; that is, they have inadequate insurance protection for major hospital and medical expenses (3).

Problem: Costs Continue To Rise

Total national health care expenditures have risen from \$75 billion in 1970 to approximately \$600 billion in 1989 (4). Health care costs increased at an average annual rate of 17% from 1970 to 1988; at the same time, all items of the consumer price index increased at an average annual rate of 11% (5). These dramatic increases in health care costs have generated ever greater pressures for cost containment. Efforts by employers, the government, and third-party payers to control rising costs are increasingly intruding on clinical decision making and are undermining physician-patient relationships.

Administrative costs (that is, the costs of recording, billing, reviewing, processing, auditing, and justifying medical liability charges) are among the fastest rising components of health care costs. Included in these expenses are the costs of insurance marketing, the profits and reserves of government and private insurance carriers, and other overhead expenses necessitated by our current health care payment mechanisms. The total costs of health care administration in the United States are estimated to be approximately 22% of all personal health care spending (6), amounting to \$110 billion in 1989. Substantial additional costs are generated by the medical liability system and efforts by physicians to minimize the exposure to claims of professional malpractice. The number of professional liability cases, the size of malpractice awards, and the costs of malpractice insurance continue to rise.

* This paper was authored by Jack A. Ginzburg and Deborah M. Prout and was developed for the Health and Public Policy Committee by the State Health Policy Subcommittee and the Health Care Professions Subcommittee. Members of the Health Care Professions Subcommittee were: F. Daniel Duffy, MD, Chair; Robert A. Berenson, MD; John Noble, MD; John R. Hogness, MD; Walter W. Kamey, MD; Gerald E. Thompson, MD. Members of the State Health Policy Subcommittee were: Donald I. Feinstein, MD, Chair; Robert B. Cope land, MD; William O. McMillan Jr, MD; John T. Harrington, MD; Cecil O. Samuelson, MD; Stewart E. Dadmun, MD. Members of the Health and Public Policy Committee were Paul F. Gruner, MD, Chair; Thomas P. Almy, MD; Donald I. Feinstein, MD; H. Dennis Scott, MD; Quentin D. Young, MD; F. Daniel Duffy, MD; Lockhart B. McGarr, MD; Lynn B. Tepley, MD; Richard G. Farmer, MD; John M. Eisenberg, MD; Jerome P. Kassirer, MD; Steven A. Schroeder, MD; Sankey V. Williams, MD; Edwin P. Maynard, MD. This paper was approved by the Board of Regents on 2 February 1990.

Problem: A Burdensome System for Patients, Their Families, and Physicians

Current health care payment mechanisms, involving multiple public and private insurers and third-party payers, are complex, confusing, costly, wasteful, and intrusive. Health insurance coverage under private insurance plans as well as under public programs, such as Medicare and Medicaid, is generally difficult to understand and requires complex mechanisms for recording, billing, auditing, reviewing, and processing claims. Patients, their families, and physicians must complete a multitude of forms, often for several carriers, involving significant time and expense. Patients and their families are burdened with this paperwork when they are most vulnerable—worried and sick.

Physicians must also respond to demands for documentation and justification from insurance carriers and quality review organizations. These frustrating layers of review, which involve demands to justify clinical decisions, requirements for prior approval, and denials of payment, undercut provision of high-quality care for all patients by inappropriately second-guessing professional judgments and intruding into physician-patient relationships. The time and expense required to deal with these administrative burdens further limit the ability of physicians to care for patients.

Criteria for a Better System

To evaluate proposals for achieving a better health care system, we identified and used the following criteria. These criteria are not intended to be all inclusive and are listed categorically rather than in order of priority.

Benefits

1. There should be a mechanism for determining the scope of benefits.
2. There should be a uniform minimum package of benefits for all.
3. Coverage decisions should be based on clinical effectiveness.
4. Coverage and benefits should be continuous and independent of place of residence or employment.

Financing

5. Financing should be adequate to eliminate financial barriers to obtaining needed care.
6. There should be mechanisms for controlling costs.
7. Administrative expenses and procedures should be minimized.
8. Professional liability costs should be minimized.
9. Existing sources of revenue should be incorporated into any new financing system.

Organization and Delivery

10. There should be an adequate infrastructure in terms of facilities and manpower to deliver optimum health care services efficiently and effectively.
11. There should be mechanisms to assure quality.

12. Innovation and improvement should be fostered.
13. The system should be flexible.
14. Incentives should be provided to encourage individuals to take responsibility for their own health, seek preventive health care, and pursue health promotion activities.

Satisfaction

15. Patients should be satisfied.
16. Physicians and other health care professionals should be satisfied.

Alternative Proposals for Extending Health Insurance Protection

Addressing the problems of inadequate access, cost control, and excessive administrative burdens are not competing objectives. These problems can be addressed simultaneously, and solutions should not be seen as being mutually exclusive. Six major types of proposals for improving access to health care are described and evaluated against the above criteria. The proposals and our conclusions concerning their advantages and disadvantages are summarized as follows:

Proposal 1: Encourage Individuals and Employers to Purchase Private Insurance

Private insurance has been a successful financing mechanism for most Americans. However, efforts to encourage individuals to purchase insurance would not be effective in assuring protection for those lacking insurance who are unemployed, have low incomes, or have been denied coverage. Tax credits and other means of subsidizing private insurance premiums are expensive and ineffectual in expanding financial access to health care.

Proposal 2: Mandate Employer Coverage

Requiring all employers to provide a package of health insurance benefits could extend insurance coverage to approximately two thirds of the uninsured population and could improve coverage for many who are underinsured. However, this approach would provide only a partial solution and would need to be coupled with other remedies. It could contribute to increased unemployment, and it would leave unaddressed the inefficiencies and inequities of current insurance mechanisms, including high overhead costs and multiple and conflicting administrative burdens for health care providers and patients. However, because of its ability to expand coverage rapidly for a significant portion of the uninsured population, this mechanism warrants consideration as a partial, short-term solution.

Proposal 3: Create Health Insurance Risk Pools

Creation of health insurance risk pools, similar to automobile insurance risk pools, would spread insurance risks for those who are in small groups or denied coverage. However, unless substantial subsidies are provided, the premiums of risk-pool members could be

much higher than those of persons with comparable group insurance and would be largely unaffordable. Creation of risk pools for "uninsurable" persons could encourage greater selectivity among insurance companies, resulting in more persons being denied individual, private policies and being shifted into a risk pool.

Proposal 4: Extend Medicaid Eligibility

Expanding Medicaid eligibility might be a desirable, short-term means for improving financial access of health care services for those who are poor or nearly poor but do not qualify for public assistance. Establishing uniform, minimum eligibility standards could reduce some of the present inequities in coverage and benefits among the states. These improvements would require substantially greater amounts of federal and state funding, amounts that would be difficult to achieve at a time of budgetary constraints. Overall, this approach could serve as an interim means for improving access for low-income groups, particularly for those below the poverty level who qualify for Medicaid in some states but not in others. However, because of the social-welfare nature of the program and the low payment rates that restrict access to care, we do not advocate this approach as the primary, long-term means for increasing access to health care for all Americans.

Proposal 5: Expand Charity Care

All physicians and other health care providers should voluntarily provide care on a charitable basis to patients who are in need and lack the resources to pay customary charges. However, there are inherent risks to patients and society in a system that relies solely on benevolence for the provision of health care services. History has shown that under such a system, health care services are not equally available to rich and poor persons typically either do not receive needed care or receive services of lesser quality. Therefore, expansion of charity care does not constitute an appropriate response to the access problem.

Proposal 6: Establish a Universal Access to Health Insurance Program

Universal health insurance programs utilize an insurance mechanism to protect all eligible participants from the costs of health care services. A universal access program could be provided through either the public or private sectors or by some combination of both. The key feature would be that a uniform insurance mechanism would spread the risks of health care costs equitably on a nationwide basis.

The primary advantages of a universal access program are that everyone is covered and that coverage is continuous, regardless of changes in place of residence or employment. All participants are covered for specific health insurance benefits and have financial access to mainstream health care. Nationally administered programs in other countries have administrative costs that are much lower than those now borne in the United States, primarily because there is less administrative

overhead involved in the billing, processing, and collection of claims. Disadvantages include the potential for greater governmental intervention in the practice of medicine and in clinical decision making, loss of physicians' ability to set fees, more intense pressure for cost containment, and more overt rationing of health care services.

Conclusions and Recommendations

Having reviewed the major, alternative types of proposals for financing access to health care services for all Americans, the College concludes as follows:

A nationwide program is needed to assure access to health care for all Americans, and we recommend that such a program be adopted as a policy goal for the nation. The College believes that health insurance coverage for all persons is needed to minimize financial barriers and assure access to appropriate health care services.

Assuring access also involves issues of cost and quality. The medical profession bears responsibility to ensure that acceptable, appropriate, and cost-effective care is delivered.

Although several of the proposals that we reviewed provide necessary short-term solutions to aspects of the access problem, it is our position that a longer-term view is necessary:

A comprehensive and coordinated program to assure access on a nationwide basis is essential. In the near term, given the urgency of the need, it could build on the strengths of existing health care financing mechanisms. In the longer term, careful consideration of innovative alternatives, including some form of nationwide financing mechanism, will be necessary.

Expansion of Medicaid and mandated employer health insurance require immediate consideration for bringing prompt relief to a large segment of the population presently without adequate access to health care. Although these short-term approaches have serious negative implications for achieving long-term reform, they would bring an immediate amelioration of intolerable conditions.

The entire structure of the American health care delivery system must be carefully examined. Alternative approaches for achieving greater access to health care services must be carefully considered, including the possibility of a unified insurance mechanism. The staggering administrative burden of the present system, both in the obvious expense of its administration and in the rising bureaucracy and paperwork that it engenders, drives us towards this conclusion.

Therefore, we urge extreme caution in merely building on the present structure. Although this approach has appeal for various political and practical reasons, we will continue to argue that some proposed solutions should be considered short-term remedies and that the time has come for a thoughtful re-examination of all aspects of the present health care system.

Serious consideration of any form of a universal access to health insurance program would be likely to generate considerable controversy and could be divisive for the medical profession. Adoption of such a program would involve a substantial restructuring of the entire U.S. health care system and, therefore, should be approached thoughtfully and with caution. Experience with the Medicare and Medicaid programs has given many, if not all, physicians cause to be leery of further governmental involvement in health care and skeptical that significant administrative savings would be achieved under yet another national program. Nevertheless, we believe that there is much that can be done to improve the accessibility, quality, and efficiency of our health care system. Some type of coordinated, comprehensive program is required on a nationwide basis.

The College does not pretend to have the answer to how the nation can best achieve universal access to health care. We do, however, wish to highlight the

urgency of the need to address this issue. Maintenance of the basic infrastructure for the provision of health care is a national priority; reliance solely on private charity or the efforts of individual states to meet this national need will be insufficient. This paper concludes with an appeal for open and thorough consideration of all options for improving access to health care, including consideration of proposals for universal health insurance mechanisms.

This paper is intended to facilitate further discussion by helping our members to understand the factual underpinning of the present problem, setting forth initial criteria for evaluating proposals, and clarifying our philosophical commitment to developing both short-term solutions and achieving longer-term reform. This document raises many questions while highlighting our concerns about the present system and our commitment to developing a better system for meeting the needs of all Americans.

Position Paper

Introduction

Since its founding in 1915, the American College of Physicians (ACP) has espoused a commitment to "enlighten and direct public opinion with regard to the great problems of health and medicine" and to ensure "the enactment of just medical laws." It is fully consonant with this mandate that the College comment on issues related to assuring that needed health services are available in this nation.

The present state of our health care system lends a new urgency to the task of addressing and resolving problems facing the system. In particular, we are deeply troubled by the large numbers of Americans without adequate access to health care services; inordinate increases in health care costs, including the costs of marketing, health insurance, and malpractice insurance; cost containment actions that undermine the basic infrastructure, including facilities and personnel, on which delivery of services depends; and growing administrative burdens and increasing intrusion into the practice of medicine by government and other third-party payers.

Growing pressures from government and business to contain health care costs have resulted in restrictions on the provision of health care services and have eroded physicians' ability to determine and provide patient care. Medicine is suffering from the paradox of being clinically able, but financially unable, to fulfill its mission of caring for those in need. Not only are these factors a source of frustration and demoralization to physicians, they threaten our self-definition as a caring and humane society. It is overwhelmingly clear that more vigorous efforts must be made to address these and related problems.

During the past 2 years, the College has attempted to

develop an objective response to the problem of access. This process has involved the policy committees of the ACP, the Board of Governors, the Board of Regents, members attending presentations at the Annual Scientific Session, and members attending ACP regional meetings. Advice and recommendations have been received from many persons. Deciding on and achieving needed change will require the commitment and participation of many more of our members. This paper constitutes one element of an ongoing effort to disseminate information about the difficult and complex health care access problem, to outline possible approaches for resolving this problem, and to urge participation of all concerned—physicians and laymen alike—in developing and implementing solutions.

Some aspects of this problem have been addressed in position statements previously endorsed by the College. In this paper, the principal focus is on financing health care services as a means of assuring access. The decision to focus these comments on health care financing, more specifically on expanded insurance protection, has been subject to substantial discussion. "Insurance," as used in this paper, is defined generically to include all public and private programs for the payment or reimbursement of health care expenses, including self-insurance plans and prepaid programs such as health maintenance organizations. The conclusion has been reached that although other mechanisms can be designed to provide health services (for example, systems of free clinics), health insurance dramatically enhances the patient's ability to select the site and provider of care. This ability to "vote with your feet" is an important check on the system and is a vital means of ensuring sufficient competition to foster a commitment to quality, respond to patient needs, and assure that facilities are adequately maintained.

Obviously, in addition to financing care, cost and quality are critical elements of the challenge. We do not

attempt to duplicate in this document our previous recommendations on these essential issues. All health care providers, especially physicians, have a professional responsibility to ensure that optimal, appropriate, and cost-effective care is delivered.

That which follows constitutes the College's initial analysis of issues that are critical to understanding and responding to the problem of financial access to care and the burdensome aspects of the current situation. It states our fundamental position on the need to assure access to health care and indicates the direction for further discussion, analysis, and action. We are pleased to note the wealth of new ideas that has been advanced recently. It is particularly heartening to see that many individuals and organizations have turned their attention to this pressing national problem. Recent articles in major journals and reports of prestigious study groups and commissions will receive our future analysis. We expect that this document will provide a policy framework for our own ongoing analysis as well as for those of other concerned parties.

The Present System: Problems Faced by Patients and Physicians

Problem: Inadequate Access to Health Care

To be without adequate health insurance protection for the costs of medical and surgical services, hospital care, prescription drugs, and outpatient services means that the patient and his or her family must rely on personal financial resources, obtain care on a charitable or uncompensated basis, or forego care. Consequently, proper care is often delayed until problems become serious, and conditions that could be effectively and economically treated on an outpatient basis often require untreated until hospitalization is required. A 1986 survey by the Robert Wood Johnson Foundation (7) indicated that as many as 38.8 million persons needed health care during the previous year but had difficulty obtaining it. Approximately 45 million persons with chronic or serious illnesses had not been seen by a physician in the previous 12 months.

In addition to the medical complications and the unjustifiable pain, suffering, and expense that can result from failure to obtain timely diagnosis and treatment, lack of an adequate financing mechanism to assure access to needed health care services results in funding shortfalls that jeopardize the entire infrastructure of the nation's health care delivery system. The amount of uncompensated care provided by hospitals increased from 5.1% of total expenses in 1980 to 6.3% (approximately \$7.5 billion) in 1988 (8) and is expected to continue to rise as the number of uninsured persons continues to increase (9). However, the burden of providing uncompensated care is not shared equally among the nation's hospitals, and more than one fourth of the care provided by public hospitals is uncompensated (10).

Financial limitations and an increasingly competitive health care environment have forced many hospitals—both for-profit and not-for-profit—to seek to curtail the amount of uncompensated care they provide and to shift uninsured patients to public hospitals. More than

1 million Americans are turned away from hospitals each year, because they lack insurance or other means to pay for care, and many of the uninsured persons who require emergency care are transferred to public hospitals (10). As public hospitals then raise prices for their privately paying patients in attempts to recover uncompensated costs, they become less able to compete successfully for privately paying patients.

In 1984, bad debts and charity care cost hospitals \$5.7 billion, or 4.6% of their total costs (8). Over 50 public hospitals were sold to private, for-profit chains between 1981 and 1984. Many public hospitals are now in financial distress. If this trend continues, access to health care for uninsured persons will be further diminished as private hospitals accept fewer uninsured patients and more public hospitals are forced to close. Without a financial base of insured or privately paying patients, public hospitals are finding it increasingly difficult to provide care that is equal in quality to that provided in private hospitals. Unless they are reimbursed adequately for uncompensated services, they will be forced to close or curtail their services.

Problem: Inadequate Health Insurance Protection

Insurance Coverage Is Uneven

Health insurance comes in various forms designed to meet different health care needs. Major forms of insurance include coverage for hospital expenses, physician services, major medical expenses, disability (both short- and long-term), dental care, and vision services. Coverage for mental health care services, long-term health care, and home health care is also available but to a much more limited extent. Private sector insurance is provided by both commercial insurance companies and not-for-profit organizations such as Blue Cross and Blue Shield and employer benefit funds. About 66% of all persons with private health insurance and 75% of all covered workers obtain their insurance through employer-sponsored group benefit plans. Approximately 147 million Americans have health insurance coverage through an employer-sponsored plan (1).

Individuals as well as groups may have overlapping and duplicative coverage; consequently, it is difficult to determine precisely how many persons are insured. The Health Insurance Association of America (HIAA) estimates that more than 181 million Americans (76% of the civilian noninstitutional population) have one or more forms of private insurance protection. Approximately 160 million persons under 65 years of age and 21 million persons 65 years of age and over have private health insurance (1).

Public-sector health benefit programs include Medicare, Medicaid, and Workers' Compensation. Health care services also are provided either directly or under contract to eligible beneficiaries by the Department of Veterans Affairs (VA), the Public Health Service (including the Indian Health Service), the Department of Defense (including the Civilian Health and Medical Program of the Uniformed Services [CHAMPUS]), public hospitals and community health centers, and state and local public health programs.

Almost 30 million persons 65 years of age and over and approximately 3 million disabled persons have

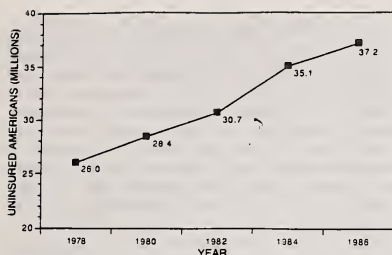


Figure 1. Uninsured persons in the United States by year.

Medicare Hospital Insurance (Part A), and more than 98% of these persons have also elected Medicare Supplemental Coverage (Part B) (2). Approximately 23 million persons are covered by Medicaid; of these persons, more than 3 million are elderly. To qualify for Medicaid, applicants must meet specified income and assets criteria and must be elderly, blind, disabled, or part of a qualifying family with dependent children. Income and asset eligibility standards vary widely among the 50 states (see Appendix 1). In 1989, the average income threshold for a family of three to qualify for Medicaid was \$4942, approximately 49% of the federal poverty level of \$10 080 (11). Coverage and benefits under Medicaid are very restricted. Payment rates are also very low, and access is limited to health care providers who accept the Medicaid payment as payment-in-full. The Department of Veterans Affairs provides health care to those who qualify among the nation's 27.5 million veterans, and the Indian Health Service provides health care for approximately 1 million Native Americans.

Millions Are Uninsured

Estimates of the number of persons without any form of health insurance coverage range from 31 to 37 million (3, 12). The figure of 37 million has been generally accepted, but recent data from the U.S. Bureau of the Census (12) suggest that the number may be as low as 31.1 million. The lower estimate is based on data from the Bureau of the Census' March 1988 population survey which included more comprehensive questions on health insurance than it had in the past. Some policy analysts have disputed the validity of the revised estimates.

Nevertheless, the latest available, detailed analyses of national population data are based on the earlier estimate of 37 million uninsured persons (13). These data show that the number of uninsured persons rose by over 1 million each year between 1978 and 1986 (Figure 1). It indicates that approximately 55% of uninsured persons are employed adults; 32%, children; and 13%, unemployed adults. More than half of uninsured non-agricultural workers are employed in the retail or service industries. However, even in the professional and related service industries, in which many workers are highly skilled, almost 10% of workers are uninsured. One quarter of the nation's nearly 12 million self-em-

ployed workers are uninsured, representing approximately 16% of all uninsured workers (13).

More than half of uninsured persons live in families of full-time workers who are steadily employed. The remainder live in families headed by workers who are sometimes unemployed, seasonal workers, part-time workers, or nonworkers. Although most uninsured persons were in families headed by someone who was fully employed, the wages of these workers were generally low (13). Three quarters of the uninsured workers earned less than \$10 000 and nearly 93% earned less than \$20 000 in 1985. Overall, one third of all full-time, fully employed workers who earned less than \$10 000 in 1985 were uninsured (13).

Low-income workers and those in seasonal or part-time sectors of the work force often are caught in a gray zone: they are not covered by employment-based insurance but not eligible for Medicaid. Such persons must "spend-down" their income and deplete any savings or other assets they might have to levels of destitution before they qualify for Medicaid. In 1985, there were 14.2 million persons considered to be poor (family income below the poverty line) or nearly poor (family income below 125% of the poverty line) who did not qualify for Medicaid and lacked any other form of public or private insurance coverage (13). Between 1975 and 1987, the proportion of poor and nearly poor Americans covered by Medicaid fell from 63% to 53%; however, the number of persons with family incomes of less than 125% of the poverty line grew from 37.2 million to 43.5 million, an increase of 17% (12).

Others Are Underinsured

In addition to those without any insurance protection are those with discontinuous coverage (due to breaks in employment or other disruptions of coverage) and those with limitations in coverage such that, despite having commercial insurance, Blue Cross and Blue Shield, Medicare, or Medicaid, they face significant out-of-pocket charges when they seek medical care. On paper, Medicaid coverage may appear adequate but, in reality, many who are eligible for Medicaid have difficulty obtaining care, because Medicaid's low reimbursement rates frequently limit access to mainstream medicine.

Definitions of underinsurance are typically linked to the adequacy of coverage for catastrophic health care expenses. "Catastrophic" can be defined either based on fixed dollar amounts of out-of-pocket costs, such as \$1000 or \$2000, or as a percentage of family income, typically 10% or 15%. A 1984 study (14) that based its definition on the out-of-pocket expenditures that a nationally representative sample of persons were at risk for paying in 1977 (after taking their health insurance into account) found that from 8% to 26% of the privately insured population under 65 years of age was underinsured; the intermediate estimate was 13%. The proportion of uninsured persons depends on the degree to which protection against the small possibility of incurring large uninsured expenses from an unusually serious illness is emphasized in the definition. Three definitions for being underinsured were used:

1. Persons with a 5% probability of out-of-pocket expenses exceeding 10% of family income.
2. Persons with a 1% probability of out-of-pocket expenses exceeding 10% of family income.
3. Persons with or without hospital insurance with inadequate protection for out-of-pocket hospital expenditures.

Using these three different definitions, the study found that the total number of persons with inadequate health insurance coverage ranged from 2.5 to 4 times the number of persons who were always uninsured or 24% to 37% of the U.S. population in 1977. The study concluded that approximately 27% of the population, 50.7 million persons in 1977, had inadequate or no insurance coverage (14).

Implementation of provisions expanding coverage under the Medicaid program (provided in the Catastrophic Health Insurance Act of 1988 and retained when that legislation was repealed in 1989) will affect the number of persons who are underinsured. These provisions extend Medicaid coverage to qualifying, pregnant women and children who meet statutorily specified levels of poverty. They also require state Medicaid programs to pay Medicare premiums and cost-sharing amounts for Medicare beneficiaries with incomes below the federal poverty line. These provisions should reduce, but certainly not eliminate, the number of persons who are underinsured.

Problem: Costs Continue To Rise

Total health care expenditures in the United States increased steadily from \$75.4 billion in 1970, to \$248.1 billion in 1986, and to an estimated \$647 billion in 1990. Health care spending rose from 7.4% of the gross national product (GNP) in 1970, to 9.1% in 1980, and to approximately 12% in 1989. Approximately 41.6% of these expenditures came from public sources (30.2% federal, 11.4% state and local); the remainder were private expenditures (2).

The United States leads all other industrialized countries in the share of total domestic expenditures devoted to health care. In 1987, total domestic health expenditures among the 24 countries comprising the Organization for Economic Cooperation and Development (OECD) ranged from 3.5% of the gross domestic product (GDP) in Turkey to 11.2% in the United States; the mean was 7.3%. Average total health expenditures as a percentage of GDP for OECD countries have remained relatively stable since 1980, fluctuating only from 7.0% to 7.4% (15).

Canadian health care costs, which during the 1960s were similar in proportion to those of the United States (approximately 6% of the GDP), remained relatively constant at approximately 8.5% of the GDP during the 1980s (15). The difference between the growing level of U.S. health care expenditures and the stable level of Canadian health care expenditures is generally attributed to the enactment of national health insurance legislation in Canada and the adoption of Medicare and Medicaid in the United States, both of which occurred in the mid-1960s.

Personal consumption expenditures in the United

States for medical care (for example, private spending for direct health and medical services to individuals and spending by Medicare and Workers' Compensation and Temporary Disability Insurance) amounted to \$400.8 billion in 1987. This figure represented 12.5% of Americans' disposable income in 1987, up from 9.7% in 1980 and 7.7% in 1970 (16). Meanwhile, the proportion of disposable income devoted to housing and transportation remained relatively stable, and the share of disposable income spent on food and clothing actually declined (17).

Public health care expenditures in the United States have increased even more dramatically, but constitute a lower proportion of the GDP than in other developed nations. In 1987, public health expenditures amounted to 4.6% of the GDP in the United States, but averaged 5.8% of the GDP in all OECD countries excluding Turkey (15).

The levels of federal spending under Medicare in the United States increased fivefold from 1970 to 1980, rising from \$7.1 billion to \$35.7 billion. By 1987, Medicare spending had increased to \$81.2 billion, more than ten times the 1970 level. Federal spending under the Medicaid program increased at similar rates, rising from \$5.2 billion in 1970 to \$49.4 billion in 1987 (18). There are many reasons for these increases: greater numbers of elderly persons are living longer and receiving Medicare benefits; inflation accounted for slightly more than half of the increase in medical care costs, and changes in medical science and technology resulted in improvements in medical care so that age-specific mortality rates have declined. Nevertheless, the rapid rates of increase in both public and private health care spending are generally seen as being out of control, particularly in light of increasing federal budget constraints and corporate cost-cutting pressures in a competitive environment.

The largest components of national health care expenditures are hospital care (39%) and physician services (21%) (4). Consequently, efforts to control health care costs have focused largely on these two groups. Spending for hospital services increased almost 7-fold from 1970 to 1987, and spending for physician services increased by a factor of 7.2. However, spending for some other categories within the national health care expenditures accounts for even greater multiples during the same period: 7-fold for dental services, 8.6-fold for nursing home expenditures, and 10-fold for other professional services. The costs of program administration (including the net cost of insurance) increased by a factor of 9.3, and the cost of government, public health activities (including spending by the Public Health Service, the Department of Defense, and the Department of Veterans Affairs) increased by a factor of 10.5 (4).

Total health administrative costs, including the costs incurred by physicians, hospitals, and nursing homes as well as by third-party payers, have been estimated to be approximately 22% of all health care spending in the United States (6). Developing accurate estimates of administrative costs is a complex task. Because the best available data raise one of the most serious challenges

to the present system, it is important that these data continue to be refined and scrutinized.

Commercial insurers have average administrative costs of 10.5%. Employers who resort to self-insurance for their employees' health care incur similar administrative expenses. Insurance policies that are sold as supplements to Medicare coverage—"Medigap"—policies—have some of the highest overhead costs. Premiums for individual Medigap policies marketed by Blue Cross and Blue Shield in 1984 included 81% for claims payments and 19% for overhead. For commercial insurers, only 60% represented claims payments and 40% represented overhead (19). Stated another way, for every dollar paid in premiums, 19 cents under the Blue Cross and Blue Shield plans and 40 cents under commercial Medigap plans went for administrative costs, marketing, and profits or reserves. Subsequent data for 1985 showed some improvement, with benefits payments amounting to 88.6% of premiums for Blue Cross and Blue Shield and 65.8% for commercial policies (19). However, these overhead costs were still far above the rates for Medicare, Medicaid, and the Canadian Health Care System, each of which was less than 3% (6, 20).

Hospital administrative costs amounted to \$26.9 billion in 1983 or 18.3% of the \$147.2 billion spent for hospital care. Nursing home administrative costs account for about 14.4% of nursing home expenditures, adding another \$4.1 billion to the identified national health care expenditures not spent for health care in 1983 (6).

Physicians' overhead represented the single largest segment of the health care dollar not devoted to patient care. A 1986 study by Himmelstein and Woolhandler (6) indicated that approximately 45% of physicians' gross income can be attributed to professional expenses, amounting to \$31.1 billion nationwide in 1983. These expenses include the cost of clerical staff, malpractice insurance, billing, and other office overhead necessary to complete forms, determine the proper coding for each procedure or service, maintain records, respond to utilization reviews, and comply with regulations and requirements of government and other third-party payers.

One of the fastest growing components of physician practice costs has been professional liability insurance. Average premiums for self-employed physicians have increased at an average annual rate of 21.9%, rising from \$5800 in 1982 to \$12 800 in 1986. During this period, average liability insurance premiums in internal medicine increased from \$3700 to \$7100. In obstetrics and gynecology, premiums increased from \$10 800 to \$29 300. The high premiums are attributable to increased incidence of malpractice claims and rising levels of jury awards (20).

Professional liability claims rose from 3.2 claims per 100 physicians before 1981 to 9.2 claims per 100 physicians in 1986. More than one third of all physicians had been sued at least once in their careers as of 1986; 29% of physicians in medical specialties and 51.9% in surgical specialties had been sued (20). Initial jury awards for both economic and non-economic damages averaged \$1 760 632 in 1987; the median award was \$825 000. As recently as 1980, awards had averaged \$404 726, and

the median had been \$150 000 (21). The resulting increases in professional liability premiums have accounted for an increasing share of physician practice revenues. With adjustments for inflation, nearly one sixth of the average increase in revenues of self-employed physicians were devoted to liability insurance premium expenses.

Problem: A Burdensome System for Patients, Their Families, and Physicians

Patients frequently have difficulty understanding their insurance coverage and can be deterred from filing claim forms that are complex, time-consuming, and confusing. Physicians are equally dissatisfied with the amount of paperwork that is often required by a multitude of public and private third-party payers, each with its own rules and requirements for obtaining payment. The amount of paperwork involved in recording, billing, reviewing, auditing, justifying, and explaining medical charges is tremendous, and intrudes on physicians' time for patient care. Although some administrative activities will always be necessary, most physicians believe that current administrative demands have reached an unreasonable level.

Hospitals, nursing homes, physicians, and employers must maintain a growing work force of health care administrators. Between 1970 and 1982, the number of health care administrators increased by 171%, while the number of physicians and total health care personnel increased by 48% and 57%, respectively (6). Hospitals spend vast amounts of money and manpower for tasks such as billing, marketing, cost accounting, and institutional planning. Hospital administrative costs are difficult to quantify because many health care workers have administrative functions but are classified as clinical personnel for accounting purposes.

A study by the American Medical Association (22) found that physician office staff spend an average of 46.7 hours per month processing Medicare claims and 32.6 hours per month processing Blue Shield claims. Additional time is required to complete forms for commercial insurers. Physicians estimated that it takes nearly 1 hour of staff time for each claim submitted to Medicare or Blue Shield. In addition, the typical physician personally must spend 4.6 hours per month on administrative work related to Medicare claims and 2.4 hours per month on similar work on Blue Shield claims. Surprisingly, when calculated on a per claim basis, the administrative burden was about the same, 0.1 physician-hours per claim. Nearly 14% of the 3000 patient care physicians responding to the study reported that they had resorted to using outside billing services to file claims or help meet reporting requirements and regulations. The average cost to the physician per claim processed by a billing service was \$8.50 for Medicare and \$7.80 for Blue Shield (22).

Denials of payment, demands to justify clinical judgments, and requirements for prior approval undermine professional decision making and physician-patient relationships. Physicians could better use the time and money they spend responding to demands for documentation and justification by insurance carriers and quality

review organizations in improving patient care, providing care to indigent persons, or enhancing their medical knowledge and skills. Consequently, there is growing frustration among physicians with the increasingly burdensome aspects of medical practice.

Criteria for a Better System

We have highlighted some of the major weaknesses of the current, patchwork, health care situation in the United States, including inadequate financial access, absent or insufficient insurance protection, continually rising costs, and a system that is burdensome for patients, their families, and physicians. This section seeks to identify the characteristics of a more ideal system. In it, we will analyze proposals for increasing access to health care in light of these criteria. The criteria below are not intended to be all inclusive and are listed categorically rather than in order of priority.

Benefits

1. *There should be a mechanism for determining scope of benefits.*

An effective health care system should have a rational basis for determining the scope of benefits that are covered and for prioritizing these benefits. The system may not be able to accommodate financially the clinical capacity to provide all possible services.

Our policy committees have struggled in an effort to develop a definition of an appropriate package of benefits, including whether such benefits should be defined as "basic" or "essential" health services. Despite these efforts and the efforts of those of our members who responded to our surveys, there is little that does not seem to be, in some way or under some circumstances, either basic or essential. The central challenge, therefore, is how best to select and prioritize the vast array of services which could be made available. We need clearly defined roles for both clinical recommendations and priority setting and a separate process to determine what is financially and practically feasible.

The medical profession must be actively involved in determining clinical appropriateness and effectiveness. However, the process for clinically based recommendations on services should be kept separate from but be fully informed by the necessarily societal and political determination of what is feasible. In this way, all citizens can be more fully involved in this debate, thereby raising public awareness of the complex problem of appropriate allocation of societal resources. Any decisions to curtail or limit coverage based on costs or budgetary considerations should be made with full representation of all concerned parties, including patients and physicians.

2. *There should be uniform, minimum benefits.*

There should be a uniform, minimum package of health care benefits for all. These minimum benefits should be "universal," that is, available to everyone. Coverage must not vary geographically as it does presently among both public and private insurance plans

because of different judgments among carriers as to what is and is not appropriate. For example, coverage now varies widely among private plans for such services as cosmetic surgery, home health care, psychiatric services, and preventive health care.

Even under the Medicare program, although uniform guidelines and criteria for making coverage determinations are provided to all contractors, each of the 48 carriers, 57 intermediaries, and 54 professional review organizations (PROs) has discretion in making its own coverage decisions (23). If a national coverage policy decision has been issued concerning a particular item or service, all Medicare contractors are bound by it. If there is no national policy, each contractor makes its own determination. The inequities of this highly decentralized process become most apparent to beneficiaries who, on moving from one state to another, find that the services that had been reimbursable through their previous Medicare contractor are not covered by their new carrier.

Physicians dealing with more than one Medicare contractor and with multiple insurance companies are faced with conflicting coverage policies. These conflicts add to their administrative burdens and necessitate additional documentation and paperwork to process claims that may be denied or subjected to various review processes. Lack of a uniform minimum coverage policy is perplexing to both patients and physicians and results in inequitable access to some health care services.

3. *Coverage decisions should be based on clinical effectiveness.*

An ideal health care system would provide insurance coverage and payment for appropriate and efficacious health care services but would not cover services that are inappropriate, ineffective, or unnecessary. Currently, there is a lack of clinical data on the effectiveness of many medical tests and procedures and a lack of scientific knowledge of what constitutes appropriate care for specific patient conditions or problems. Much research has been done to evaluate new medical practices and technologies. Examples include the ACP Clinical Efficacy Assessment Project, the Patient Outcome Assessment projects supported by the National Center for Health Services Research and Health Care Technology Assessment, the randomized controlled clinical trials sponsored by the National Institutes of Health, and research by the Office of Technology Assessment and the Health Care Financing Administration. However, the total amount of this research, generally known as health services research, has been minuscule in relation to national health care expenditures. Scientific knowledge on effectiveness and appropriateness is still very limited. Consequently, public and private health insurance plans make coverage decisions based on limited scientific data, determinations of existing norms of care, patient demand, and political and economic considerations.

Ideally, all new—as well as existing—medical tests, procedures, and technologies should be evaluated scientifically to determine their clinical efficacy and appropriate conditions of usage. Procedures that are determined to be ineffective or inappropriate should not be

covered. Research priorities will need to be set and coverage decisions reviewed as scientifically sound data become available. The Institute of Medicine (24), the National Leadership Commission on Health Care (3), and the Physician Payment Review Commission (25) have indicated that several hundred million dollars in additional federal funding will be needed each year to expand clinical effectiveness research. The College has strongly supported legislative efforts to increase the level of health service research funding.

4. *Coverage and benefits should be continuous and independent of place of residence or employment.*

Participants should continue to have access to covered health care services regardless of place of residence or employment status. Coverage should be "portable"; persons changing jobs or moving from one state to another should not lose their health care benefits.

Financing

5. *Financing should be adequate to eliminate financial barriers to obtaining needed care.*

The financial burden for the program should be shared progressively. Any premiums, copayments, deductibles, or taxes used to finance it should be based on ability to pay.

6. *There should be mechanisms for controlling costs.*

Cost containment measures are essential to any health care financing system. Payments should be made only for necessary and appropriate care. There should be incentives for patients to obtain and for health care providers to deliver health care services in a cost-effective manner. Charges and payments for health care services should be based on objective determinations of reasonableness.

7. *Administrative expenses and procedures should be minimized.*

Administrative burdens on patients, physicians, hospitals, and other health care providers should be kept to a minimum. Requirements for billing and completion and processing of forms and other paperwork should not deter health care professionals from working within the system. Providers of health care should not be subjected to complicated and differing rules and requirements from a multitude of insurers and other third-party payers. Likewise, the cost of administering the program, including program costs as well as the administrative overhead of insurance carriers and fiscal intermediaries, should be minimized so that a high proportion of program outlays are devoted to delivery of health care services. Finally, the system should promote efficiency, with insurance agencies sharing information and providing coordinated coverage and benefits.

8. *Professional liability costs should be minimized.*

The direct costs of medical malpractice insurance as well as the indirect costs of added tests and procedures

done to reduce the risk for malpractice litigation add significantly to overall health care costs. These costs have continued to rise due to many factors, including the increasing proclivity of patients to sue, legal fees that are contingency-based, excessive jury awards for pain and suffering, and tendency of insurance companies to agree to out-of-court settlements. Restructuring of the professional liability system, including necessary elements of tort reform, should be an integral part of health care reform.

9. *Existing sources of revenue should be incorporated into any new financing system.*

For a new system to be financially viable, it must, when possible, continue to capture those resources currently financing health care services. Some savings, of course, may ultimately result under a more efficient system and should be shared among contributors. It is critical, however, that resources now available to the system not be lost, although they may assume a different form. For example, resources from employers presently providing coverage and governmental programs, such as Medicare, Medicaid, CHAMPUS, and VA programs, should be incorporated.

Organization and Delivery

10. *There should be a sufficient infrastructure in terms of both facilities and manpower to deliver health care services efficiently and effectively.*

Health care facilities—hospitals, outpatient clinics, skilled nursing homes, home health agencies, and hospices—should be available to meet the full continuum of health care needs. Likewise, the supply of physicians, nurses, and other health care professionals should be adequate to meet requirements for professional services. A new health care financing system must be analyzed in terms of its impact on public hospitals to ensure that the necessary infrastructure for delivery of services is sufficient to meet patient needs. Health planning will be needed to ensure that resources are allocated to meet needs best and to avoid unnecessary duplication, waste, and inefficiency. National policies on manpower will need to ensure that sufficient numbers of the right kinds of physicians and other health care professionals are educated and trained to provide patient care services as well as to meet national needs for teaching, research, and administration.

11. *There should be mechanisms to assure quality.*

Quality assurance and utilization review should be provided through accepted mechanisms: accreditation and certification standards for institutions, and peer review and other quality assurance mechanisms for health care providers. Patients must be able to express their satisfaction or dissatisfaction with the quality of services they receive by choosing among providers.

12. *Innovation and improvement should be fostered.*

Sufficient resources must be devoted to research and development to achieve continued advances in medical science. The system must be responsive to scientific

advances, improvements in technology, and changes in medical practice. Issues of maintenance of the health care infrastructure have to be addressed. It is critical that capital resources be available on a continuous basis to enable new construction, restoration and maintenance of existing facilities, and purchase of new equipment and other capital improvements.

13. *The system should be flexible.*

The financing system should be responsive to variations in patient care needs and preferences concerning how services are organized and delivered. It should recognize the pluralistic nature of our society, accommodating differences in population, culture, and location. The system should permit various organizational models for delivery of health care services, including private practice, group practice arrangements, health maintenance organizations, and preferred provider organizations.

14. *Incentives should be provided to encourage individuals to take responsibility for their own health, seek preventive health care, and pursue health promotion activities.*

Health promotion and preventive health care are effective means for improving the nation's health and reducing health care expenditures. The health care system should, therefore, encourage prenatal care, maternity care, well-child care, immunizations, physical exercise, good nutrition, healthful life styles, and similar activities that contribute to good health. The system should also encourage Americans to cease unhealthy activities such as smoking, alcohol abuse, and drug use.

Satisfaction

15. *Patients should be satisfied.*

The health care system should be satisfactory to patients in terms of meeting their health care needs and providing services. Patients should be able to choose their own physicians and the type of setting from which they obtain health care services. Patients who are dissatisfied with the services they receive should not be unduly restricted from changing physicians or providers. The freedom of patients to choose their own physicians is an important safeguard for assuring quality of care.

Patients should also be able to understand easily how to obtain and pay for care. The financing system should not be so complex that patients cannot readily obtain the care they need. Any use of insurance or claims should be fairly simple, so that patients can pay for the services they receive and obtain appropriate reimbursement.

16. *Physicians and other health care professionals should be satisfied.*

The health care system should foster an environment in which physicians can work effectively and be reasonably satisfied. Such an environment would provide appropriate compensation for physician services and

would allow physicians to practice without undue outside interference in clinical decision making or burdensome administrative and paperwork requirements.

Appropriate professional judgment should not be impeded. Making clinical diagnoses and decisions regarding the management and treatment of disease are challenges that are hallmarks of the medical profession. Inappropriate infringements on this activity may discourage the most promising candidates from seeking or remaining in medical careers. Therefore, the financing system should not unduly influence clinical decision making, except to the extent that payments should not be provided for inappropriate and ineffective services. Physicians and other health care professionals must be able to determine the most appropriate course of treatment, within the necessary limitations of their scope of expertise, the circumstances of specific patient situations, scientific knowledge, and clinical standards. This is one of the major challenges that attracts students to enter careers in medicine. Unreasonable infringement on professional judgment in patient care decision making limits physicians' ability to care best for their patients and is a major source of frustration for those in practice.

Proposals for Extending Health Insurance Protection

The following section briefly summarizes and analyzes, in light of the above criteria, six major types of proposals that use insurance mechanisms for expanding access. As previously noted, other mechanisms can be designed to deliver health care services; however, we believe that an insurance mechanism would be preferable because it enhances the ability of each individual to select both the site and provider. Each of the generic categories of proposals discussed below could be fulfilled by many variously structured plans for improving access to health care. For example, the generic proposal to mandate employer health insurance could be addressed by federal legislation, as proposed by Senator Kennedy and Congressman Waxman, or by the state program now in effect in Hawaii.

Proposal 1. Encourage Individuals and Employers To Purchase Private Insurance

Various incentives could be used to encourage individuals to obtain health insurance. Public education efforts could be made to inform Americans of the risks and costs of health care and the value of insurance. Federal and state tax policy could also be used to encourage individuals and employer groups to purchase private insurance. For example, the Internal Revenue Code could be revised to permit self-employed persons to deduct fully the cost of their health insurance premiums, and personal income tax rules could be revised to allow more favorable treatment of health insurance premiums as an itemized deduction. Vouchers for the purchase of insurance could also be given to qualifying uninsured individuals. However, private health insurance, whether paid by individuals, employers, or government, is expensive, and premiums are rising rapidly.

Advantages of the Voluntary, Private-Insurance Approach

1. This approach would rely primarily on a private-sector insurance mechanism and, therefore, would not be disruptive to existing financing mechanisms.

2. Individuals and employer groups would still have freedom to choose among private health insurance plans and to determine what, if any, benefits they wish to purchase.

3. This approach might appeal most to the approximately one third of uninsured persons under 65 years of age who have family incomes greater than 200% of the poverty level (about 13 million persons). Extension of a 100% tax deduction for health benefits might appeal particularly to the 2.1 million uninsured self-employed persons included in this group (16% of uninsured persons).

Disadvantages of the Voluntary, Private-Insurance Approach

1. This approach would probably not benefit the approximately two thirds of uninsured persons who have family incomes at or below 200% of the poverty line; for these persons, insurance could still be too expensive unless subsidies were provided.

2. Many uninsured persons may be fully aware of the value of health insurance, but may give higher priority to other needs.

3. Individual, private insurance is generally the most expensive form of insurance coverage. Costs are high because of the marketing, premium collection, and processing costs involved, and because insurance risks cannot be spread as well as in group insurance. Premiums also must provide a margin for profits and reserves.

4. Building on existing, private-insurance mechanisms would further increase administrative costs and would not alleviate current paperwork and administrative burdens that cause dissatisfaction for physicians and patients.

Conclusions: Encouraging Individuals and Employers To Purchase Private Insurance

Private insurance has been a successful financing mechanism for assuring access to health care for most Americans. However, most private insurance is provided through the employment setting, and efforts, such as public information campaigns or tax incentives, to encourage purchase of individual insurance, which generally costs much more than group insurance, would not be expected to benefit those with low family incomes, those who are unemployed, or those who are denied coverage. Although most existing, private insurance is provided through the workplace, voluntary expansion of insurance coverage by employers does not appear to be an effective remedy for low-income workers or those who are employed on a part-time or seasonal basis. Tax subsidies or credits for the payment of private insurance premiums, which include administrative expenses for marketing, profits, and reserves, would be an expensive and inefficient method of expanding financial access to health care.

Although a voluntary, private-sector approach might

be politically preferable to solutions that could involve government programs, this approach would not reduce the high administrative costs or burdens generated by the current system. Instead, it would perpetuate many current inefficiencies and problems. Indeed, this approach might increase insurance costs as greater efforts would be required to coordinate benefits and market individual policies. Paperwork and administrative requirements would not be reduced, but could increase as the number of insurance carriers and policies proliferates.

Proposal 2: Mandate Employer Coverage

Another option would be to require all employers to provide a package of health insurance benefits to eligible employees and their dependents. This approach recognizes that most Americans (136 million) obtain health insurance through their or a family member's employment, and about two thirds of those who are currently uninsured live in households headed by an employed person (26). Requiring all employers to provide health insurance coverage for workers and their dependents is also seen as an equitable and effective way to extend health insurance protection.

A version of this approach was adopted by the state of Hawaii in 1974. Under state law, employers are required to cover all employees who work 20 or more hours per week for at least 4 consecutive weeks. Employers must pay at least 50% of premium costs, and employee premiums are limited to 1.5% of annual wages. The state subsidizes premiums paid by firms with fewer than eight employees.

Legislation enacted in Massachusetts in 1988 would require employer-paid health insurance for all employees. Other state residents would be able to purchase insurance coverage from a state program, with premiums based on their income and family size. A payroll tax to be paid by employers would help fund health insurance for unemployed persons. However, lack of adequate funding at the state level threatens to delay implementation of this program, which was originally scheduled to begin in 1992.

Legislation to mandate employer coverage has also been considered at the national level. Bills have been introduced but not passed by Congress that would establish minimum levels of health insurance benefits to be provided by all employers. Under several proposed bills, coverage would be required for all full-time employees working a certain number of hours per week and for their dependents. Employers would be mandated either to purchase a package of minimum benefits or provide comparable benefits. The Congressional Budget Office (CBO) estimated that one legislative proposal (S.1265, 100th Congress) would have affected 51 million Americans, including 23 million previously without any coverage and 28 million whose existing coverage did not meet the bill's proposed minimum benefit requirements. The CBO estimated that this legislation would cost employers an additional \$22 billion per year (about \$900 per employee) and would cost employees \$1 billion each year (26).

Advantages of Mandated Employer Coverage

1. Health insurance coverage could be extended to approximately two thirds of those who are currently uninsured.
2. Net costs to the federal government would be negligible, with reductions in Medicare and Medicaid costs offsetting losses in federal revenues from reductions in income and payroll taxes due to elimination of jobs or decreases in wages.
3. Cost to enrollees would be relatively small, and enrollees would benefit from low group rates.
4. Workers would be assured of minimum health insurance protection, because all employers would be required to provide at least the minimum level of benefits.
5. Cost shifting among employers would be reduced. Employers who provide benefits for their employees and dependents would no longer be subsidizing (through higher insurance premiums) the uncompensated costs of caring for employees and dependents of others.
6. The problem of inadequate insurance for those covered could be addressed if all benefits packages were required to meet minimum standards.
7. Socially desirable goals, such as providing prenatal care, child care, and mental health services and prohibiting denial of coverage for pre-existing conditions, could be achieved if they were required as part of a mandatory benefits package.
8. Employers already providing benefits equal to or greater than the minimum would be unaffected.
9. Exemptions could be made for small employers or certain industries to protect them from unreasonable cost increases. Federal or state subsidization or tax credits could also be used to reduce the danger that some employers would go out of business and to protect jobs.
10. Public hospitals and other public programs would obtain some relief from demands for uncompensated care, as fewer patients would be without insurance coverage.

Disadvantages of Mandated Employer Coverage

1. Costs to employers would increase substantially when there is growing resistance to such increases.
2. Small employers of low-wage workers would be most affected. The added cost of insurance could cause some employers to go out of business, resulting in the loss of jobs. In some areas, such as inner cities with high unemployment and substantial populations without health insurance, adding to the burden of employers could exacerbate existing problems.
3. Part-time and temporary workers who do not work the requisite number of hours or weeks for an employer to be required to provide coverage would remain without access to health care.
4. Employment opportunities would be reduced for low-wage, part-time, and seasonal workers as employers seek to avoid incurring additional health insurance costs.
5. Reductions in jobs and wages would result in lower state and federal payroll and income taxes, so that the program would not be truly budget-neutral and would contribute to state and federal deficits.
6. Mandating benefits would undermine the collective

bargaining process. Health insurance benefits are a negotiable item for which wage increases or other benefits are often traded. Requiring all employers to provide specific, minimum health insurance benefits would limit the ability of employers and workers to determine which employment-related benefits are of highest priority.

7. A state-by-state approach of mandating benefits could cause substantial administrative problems for large employers operating in more than one state. Minimum benefits could be different in each state, and states without mandatory health insurance requirements might be able to lure jobs away from those with requirements.

8. Higher labor costs could make it more difficult for U.S. companies to compete in world markets and might contribute to the nation's worsening balance-of-trade problems.

9. Unnecessary and expensive insurance costs could be incurred from duplication of coverage for families with more than one wage earner.

10. Laid-off and unemployed workers could be uncovered or unable to pay insurance premiums.

11. Inadequate financing, particularly likely when state or other government funding is involved, would make the program financially unstable.

Conclusions: Mandating Employer Health Insurance

Mandated employer health insurance could immediately extend insurance coverage to two thirds of uninsured persons and would improve coverage for many underinsured persons. Uniform, national, employer coverage requirements would provide insurance protection to working poor persons who are now covered by Medicaid in some states but not in others. This approach would alleviate the financial burden on Medicaid in some states. However, this approach alone, especially if adopted on a state-by-state basis, would provide only a partial and less-than-optimal interim solution that would still leave many persons uncovered. It would perpetuate inefficiencies and inequities of current insurance mechanisms, including high overhead costs and administrative burdens for health care providers and patients. Systematic means of cost control or quality assurance are not intrinsic features of such an approach and would need to be addressed.

Proposal 3: Create Health Insurance Risk Pools

Health insurance risk pools, like automobile insurance risk pools, are a mechanism for assuring that insurance is available to high-risk persons who otherwise would be considered uninsurable. Risk pools can provide insurance protection for persons with pre-existing medical conditions or other problems, such as testing positive for human immunodeficiency virus, for which they might otherwise be denied health insurance coverage. Costs can be borne entirely by those in the risk pool or can be subsidized by government or by premiums of nonrisk-pool policies. State and federal organizations can help to reduce premiums by providing reinsurance for losses beyond a certain level.

Fifteen states have enacted laws establishing health

insurance risk pools (27). (As of February 1988, health insurance risk pools were operational in Connecticut, Florida, Indiana, Minnesota, Nebraska, North Dakota, and Wisconsin. Risk pools were being implemented in Illinois, Iowa, Maine, Montana, New Mexico, Oregon, Tennessee, and Washington.) In these states, private insurers generally must accept a proportionate share of risk-pool policies either through direct applications or by reinsurance. Federal legislation to encourage states to set up risk pools has been considered recently. Under one proposal, federal assistance would be provided for states either to establish risk pools or, for those with existing pools, to improve access to affordable insurance. Another proposal would mandate participation by all employers doing business in a state with an established risk pool.

Advantages of Risk Pools

1. By spreading risks among a large population, insurance losses are more predictable and insurance companies can provide coverage at lower group rates. Although premiums are generally higher than for non-risk-pool enrollees, they are not so high as might be required for individual coverage if it were available.

2. Some nonpoor uninsured persons (including those with pre-existing illnesses) and some small employers might be able to obtain health insurance protection that is otherwise unavailable or unaffordable.

3. Risk pools provide a joint public- and private-sector solution to the problem of uninsurability with minimal government involvement.

4. States could take the initiative for establishing risk pools. A federal reinsurance system could be established for states that do not create their own risk pools.

Disadvantages of Risk Pools

1. Premiums for risk pools are high, ranging from 125% to 150% of those for standard risk policies, even though most states with risk pools have established caps on premiums (28). Consequently, enrollment must be voluntary, and substantial public subsidies may be required.

2. Enrollment in existing state health insurance risk pools has been low. Most states with risk pools limit coverage to those who are "uninsurable" (about 1% of the population), but only a small fraction of those who are eligible actually enroll (about 20 000 of approximately 230 000 persons eligible in five states in 1985) (28). This low enrollment may be due to the relative newness of risk pools, lack of public awareness of the risk pools, or the high premiums.

3. State funding of the magnitude necessary to subsidize risk pools adequately would be difficult, given the current fiscal climate and past levels of state support.

4. The existence of risk pools may encourage insurers to become more selective in issuing individual insurance policies, forcing those who are less healthy into risk pools to obtain insurance coverage.

5. Risk pools would not reduce administrative burdens for physicians and could create additional paperwork and delays for receiving payment.

6. Risk pools could increase costs, as insurance carriers add additional administrative staff to determine eligibility and process claims.

Conclusions: Creating Health Insurance Risk Pools

Risk pools for uninsured and unemployed persons could improve access for those who are now denied coverage or are unable to purchase lower-cost group insurance. However, unless substantial subsidies are provided, premiums for risk-pool members could be much higher than premiums for comparable group insurance and would be largely unaffordable. The creation of health insurance risk pools for "uninsurable" persons could encourage greater selectivity among insurance companies, resulting in greater emphasis on marketing to those who are the most healthy and have the lowest risk. Those with previous illnesses or health histories indicating higher risk would be referred to a risk pool. Broader sharing of costs across society would be more equitable, and other devices would be preferable.

Proposal 4: Extend Medicaid Eligibility

Medicaid is a joint state and federal program to provide health care to poor persons. Coverage and eligibility standards vary widely among the states (see Appendix 1). Thirty states set the maximum income eligibility standard at less than half of the federal poverty level of \$10 060 for a family of three (11). In 1989, to qualify in Alabama, a family of three could not earn more than \$1416; in California, a family of the same size could qualify with annual earnings of up to \$8328. Families with incomes and assets above state eligibility levels must spend-down their own resources before qualifying for Medicaid coverage. Thirty-six states also provide coverage for the "medically needy." Under these programs, Medicaid coverage is available to those who incur large medical expenses and meet the categorical eligibility standard except that they may have earnings that are up to 5% above the income eligibility standard. The average income eligibility level for medically needy programs was \$6765 in 1989, 61% of the poverty level (11).

All states must provide coverage for certain services, such as inpatient and outpatient hospital services, physician services, skilled nursing facility care, laboratory, and x-ray services. State Medicaid programs differ, however, in their coverage of "optional" services, such as physical and occupational therapy, prescription drugs, inpatient psychiatric services, diagnostic and screening services, and preventive and rehabilitative services. Payment rates for physician services are generally much below customary charges, and physicians accepting Medicaid patients are required to accept the Medicaid rate as payment-in-full. Physician participation rates are low, and access for Medicaid recipients is consequently impeded.

Expansion of Medicaid eligibility would be another means of improving financial access to health care services for those who are poor or nearly poor but who do not qualify for public assistance. Under the Omnibus Budget Reconciliation Acts of 1986 and 1987, states were given the option of expanding Medicaid coverage to include pregnant women, children under 5 years of age, and elderly and disabled persons with incomes up to 185% of the federal poverty level.

Provisions retained despite repeal of the Catastrophic Health Insurance Act of 1988 have required states, since 1 July 1989, to extend Medicaid coverage to pregnant women and infants with incomes at or below 75% of the poverty line. Effective 1 July 1990, Medicaid coverage must be provided for qualifying women and infants with incomes below 100% of the poverty line. Medicaid programs must also begin paying Medicare premiums for low-income elderly and disabled persons. This coverage will be phased in over 4 years. Since 1 January 1989, states have been required to pay the premiums for qualified persons with incomes below 85% of the poverty line; by 1 January 1992, coverage will be required for those with incomes below 100% of the federal poverty line.

Other action to expand coverage could be accomplished at the state level by extending coverage to additional optional groups, adopting or expanding "medically needy" programs, or raising eligibility levels for the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs. In Oregon, the state legislature has authorized the state Medicaid program to contract with managed care systems to provide care for medically indigent persons. Under this plan, which requires a waiver of federal regulations, coverage would be extended to all state residents with incomes below the poverty level. A commission would determine and rank priorities for specific health care services based on their cost and effectiveness. Political decisions would then be made as to which services would be covered and the level of funds to be appropriated.

Although designed primarily to address the needs of poor families, state Medicaid programs now spend disproportionate amounts on care for elderly persons, particularly for nursing home and home health care. Elderly, blind, and disabled persons comprise 28% of Medicaid recipients but account for 74% of Medicaid expenditures. Only 12% of Medicaid funds are spent for care of dependent children, and 13% for care of adults in families of dependent children (29).

Advantages of Extending Medicaid Eligibility

1. Medicaid provides an existing mechanism for extending health insurance protection to uninsured persons based on determinations of their categorical qualifications, income, and resources.
2. Extension of health insurance protection could be targeted toward those who are not now eligible for Medicaid, but who have incomes that are below or near the poverty line.
3. Creation of national eligibility levels could reduce the disparities currently existing among states.
4. Extending Medicaid coverage to those with family incomes of up to 200% of the poverty level would provide protection for approximately 30% of those now uninsured.
5. Allowing some groups, such as those who have been denied private insurance because of pre-existing conditions, to buy Medicaid coverage would enable "uninsurable" persons to obtain insurance protection. Premiums could be set at average Medicaid cost or otherwise subsidized to provide low-cost coverage.

Disadvantages of Extending Medicaid Eligibility

1. State Medicaid budgets are already overburdened and could not absorb the additional costs of expanded coverage or improvements in benefits and payment rates without massive and sustained additional federal funding or other sources of revenue. Budget constraints also appear to preclude the level of federal financial assistance that the states would require.
2. Providing states with additional options for coverage would further increase disparities in eligibility and benefits among states. States with the highest proportions of unemployed or low-wage workers might be least able to expand Medicaid coverage.
3. Medicaid is often stigmatized as being a social-welfare program for the poor. Some low-income workers and their families would not apply for Medicaid even if they qualified for assistance.
4. Medicaid payment rates are low, and physicians accepting Medicaid payment are required to accept the Medicaid rate as payment-in-full. Physician participation rates are consequently low, and access is impeded.
5. Raising income eligibility levels without corresponding increases in physician participation will not necessarily assure that patients receive needed medical care. If payment rates and the number of physicians accepting Medicaid remain constant, expansion of coverage may mean that some patients have to wait longer to receive services.

Conclusions: Extending Medicaid Eligibility

Medicaid provides an existing mechanism through which coverage could be extended to some qualifying groups who now lack insurance protection. Current disparities in coverage and benefits among states could be reduced by federal legislation setting eligibility levels and mandating coverage. Disadvantages include substantially increased requirements for federal funding, the danger that potential beneficiaries will perceive services obtained through a social-welfare program as being inferior, and low Medicaid payment rates and requirements for mandatory assignment that result in low physician participation rates. In addition, expanding coverage as budgetary constraints increase could further diminish Medicaid's limited resources available for the care of poor women and children. Nevertheless, this approach could serve as an interim means for improving access for low-income groups, particularly those whose incomes are below the poverty level and who qualify for Medicaid in some states but not in others. Because of the social-welfare nature of the program and the low payment rates that restrict access to care, we do not advocate this approach as the primary means for increasing access to health care for all Americans.

Proposal 5: Expand Charity Care

Some argue that very few Americans actually are denied care when they need it. Data from the 1988 American Hospital Association annual survey (8) show that hospitals in the United States provided unreimbursed care valued at \$14.2 billion, 6.3% of their gross patient revenues in 1988. Approximately 32% of this uncompensated care was charity care and 68% was bad

debt. However, the extent of bad debt and charity care provided varied widely by type of hospital, with the highest proportions provided by public (13.3%), major teaching (10.3%), and large (685 or more beds) urban (8.8%) hospitals. Unreimbursed care as a percentage of gross patient revenues was lowest at investor- and religious organization-owned hospitals, and most of the unreimbursed care at investor-owned hospitals was bad debt. Another study (9) estimated the true cost of charity care to be only 1.2% for voluntary hospitals and 0.1% for for-profit hospitals.

Many physicians reduce charges, provide free care, or do not attempt to collect their bills for patients they know lack insurance or cannot afford to pay. The amount of uncompensated care provided by physicians is considerable but difficult to document. One recent study (30) of physicians in San Francisco reported that \$51 000 per physician practice was written off in 1985 as being uncompensated care or services that were not billed. Charity patients accounted for 7% of all physician patients, and physicians provided, on average, \$19 000 per year in services to these patients; the remaining \$32 000 was for care that was billed but not paid (30).

Physicians who treat patients covered by Medicaid and, thereby, agree to accept the low Medicaid fees as full payment are, in effect, providing charity care. The same might be said for accepting patients covered by Medicare on assignment when Medicare-approved charges are substantially lower than physicians' customary charges.

If charity care were available to those who truly need help, other public or private action might not be necessary. Some state and county medical societies have organized programs for physicians to provide free care to indigent persons. Ways to increase charity care include providing organized mechanisms for donating services (for example, establishing free clinics and community service programs), revising the tax code to permit deductions for the professional value of charitable care, and direct appeals to physicians and others to serve the poor.

Advantages of Expanding Charity Care

1. Physicians and hospitals could directly address the problem of access for uninsured persons. This approach would appeal to the innate altruism of physicians and institutions.

2. Those most in need might get help without expansion of government programs or mandates for provision of health insurance.

3. Direct costs to government and employers would not increase.

Disadvantages of Relying on Charity Care

1. Charity care would not provide equal access to health care for all Americans.

2. Many persons feel that requesting charity care is demeaning and will not seek help except in an emergency situation.

3. Data on utilization of health care services of poor persons, before and after adoption of Medicaid in 1965, show that charity care was ineffective in meeting the

health care needs of poor persons. Dramatic increases in use of health care services and improvements in indices of health status after 1965 reflected improvements in access to health care services.

4. Tax deductions for charity care could be easily abused and fraudulent claims would be difficult to detect.

5. Charity care is generally viewed as being of lesser quality than other health care.

Conclusions: Expanding Charity Care

The medical profession has a responsibility to continue to provide a certain degree of charity care. The American College of Physicians urges all physicians to provide care voluntarily on a charitable basis to patients who are in need and lack the resources to pay physicians' customary charges. However, there are inherent risks to patients and society in a system that relies solely on benevolence for the provision of health care services. History has shown that under such a system, health care services are not equally available to all, and poor persons typically either do not receive needed care or receive services of lesser quality.

Proposal 6: Establish a Universal Access to Health Insurance Program

Several proposals have been made that would use an insurance mechanism to spread the cost of health care services equitably on a nationwide basis among all eligible participants. Programs to establish universal access to health insurance do not require a system in which hospitals and other health facilities are owned by the national government or in which physicians and other health care workers are employed by the government.

Practically all industrialized countries except the United States have national health care programs to assure universal access. These programs take many different forms, but they share the common feature of being government programs designed to enable all citizens to obtain health care services without financial barriers. Coverage is generally universal (everyone is eligible regardless of health status) and uniform (everyone is entitled to the same benefits). Costs can be paid entirely from tax revenues or by some combination of individual and employer premiums and government subsidization.

One format is to have a single, uniform program administered at the national level, as in Sweden and France. Another format sets minimum benefits at the national level but allows programs to differ as they are administered at the provincial or state level (as in Canada and Switzerland). Another variation is to permit qualifying, nongovernment programs to operate at the local level (for example, through nonprofit sick funds and medical associations as in the Federal Republic of Germany). Still another arrangement is to have a national program administered through local councils (as in Belgium and the Netherlands). National health insurance programs can be operated solely by the government or can be structured to incorporate private health insurance.

The overall cost of a universal access program would depend on how the program were structured, the benefits provided, the extent of optional or exempted coverage, mechanisms to assure appropriate use of services, and various other considerations. The public or government share would depend on how private insurance were incorporated into the plan and the amount, if any, paid by employers and individuals.

Given the various ways in which a health insurance program could be structured, it is difficult to provide more specific analysis without an actual proposal. Physicians need not assume that payment rates under a universal access plan would be inadequate, although experience with Medicaid and Medicare gives cause for concern. There is also reason to be apprehensive that a universal access program could result in greater intervention in the practice of medicine by government or other payers, thus further diminishing physician autonomy.

A universal access plan could achieve substantial savings by reducing the amount of administrative expenses currently borne by physicians, hospitals, nursing homes, and others providing and paying for health care services. Aggregate savings could be achieved by reducing the paperwork and expenses involved in coding for services, billing and collecting payments from patients, and submitting and documenting claims to multiple insurance carriers—each with its own forms, coverage provisions, copayments and deductibles, and review and compliance requirements. Further savings could be achieved by eliminating much of the administrative overhead that health insurance carriers incur for administration, marketing, reserves, and profits.

Recent proposals (31, 32) suggest that a universal-access program would shift the mix between public and private expenditures and that total expenditures would not increase at as great a rate as has been sustained in recent years. At current levels of national health care spending, each reduction of 1% in the amount of total spending for administrative costs would save \$5.5 billion annually. Potential savings from reduction of administrative overhead under a national health insurance program have been estimated to be about 10% of current health care spending. Those savings might conceivably offset the costs involved in expanding access to health care (31).

Establishment of a universal access program implies that there would be some centralized planning to assure that sufficient resources are allocated to meet the nation's health care needs. Planning and financing decisions would be needed to provide appropriate health care facilities where they are most needed, to foster technologic innovation and scientific advances, and to ensure that there are sufficient numbers of appropriately trained health care professionals. Substantial investments in health services research would be required to enable the program to deliver health care services as effectively and efficiently as possible and to improve the quality of health care. Investments would also be required for research and development to permit continued achievement of advances in medical science and technology.

Financing for a universal access program could be

obtained from general tax revenues, a surcharge on income taxes, payroll taxes, or income-related premiums or by various other means, including using the savings obtained by converting from the present system. Although coverage would apply equally to all, contributions could vary according to income. Contributions could also be adjusted or waived for targeted groups, such as unemployed and poor persons, children, and pregnant women. A universal health insurance program could replace the need for Medicaid and most charity care. Additional issues, such as whether to permit the purchase of coverage beyond that provided under the program and voluntary exemptions from enrollment, would require careful analysis.

Advantages of a Universal Access to Health Insurance Program

1. All persons would have access to specific health insurance benefits covering at least essential health care services. Coverage could serve as a safety net and be supplemented by private insurance.

2. Access to mainstream health care could be provided.

3. Equity would be achieved among the states, as all persons would be eligible for national insurance coverage.

4. Lower premium rates per dollar of coverage could be obtained for a uniform package of benefits than is possible under a multiplicity of plans with varying benefits and coverage.

5. Administrative overhead would be far lower than under most private-sector plans due to savings from economies of scale. Additional savings could be obtained from the reduction or elimination of costs for billing, processing claims, marketing, reserves, and profits.

6. A minimum-coverage package could be designed to include prenatal, well-baby, and other primary and preventive care that would improve our nation's health status. Increased access to these and other health care services could result in better health and reduced costs for preventable illnesses.

7. Coverage could be optional for those with other insurance that is at least equivalent, and supplemental private insurance could still be purchased by those seeking additional protection.

8. The cost of expanding health insurance to uninsured persons could be broadly and equitably shared.

9. Costs would be offset to some extent by savings from increased worker productivity and resultant higher earnings and tax revenues (although such savings are difficult to measure); reduced payments for much more expensive sequelae and complications of neglected illness; elimination of expenditures for Medicaid and other programs; and diminished costs of so-called "uncompensated care" which is now ultimately shifted to private insurers, the public treasuries, and charities.

10. Health care providers would be assured of payment, thus reducing or eliminating bad debts and uncompensated care.

11. Planning and financing on a national scale could better assure that resources are allocated to provide the health care facilities and the manpower needed to de-

liver health care services most effectively. Adequate resources could be provided for research and development, health services research, and the education and training of needed health care professionals.

12. Administrative burdens on physicians could be reduced.

Disadvantages of a Universal Access to Health Insurance Program

1. Substantial change would be required, entailing a restructuring of health care financing mechanisms and programs.

2. Universal coverage and expansion of benefits could result in greater health care costs, thereby generating further pressures for cost containment.

3. Greater government involvement in the practice of medicine, with increasing controls on volume, utilization, costs, and quality reviews, could result in further losses of physician autonomy.

4. Governmental decisions to ration or not to pay for some procedures (for example, organ transplants) would more directly limit medical decision making and the availability of these services.

5. Centralized planning and uniform determinations of coverage and benefits could prevent development of local variations that might better meet local needs.

6. There would be a loss of clerical, administrative, and accounting jobs now required for hospitals, physicians' offices, and other health care facilities to complete and process bills and other paperwork. Employment in the insurance industry might also suffer as jobs in marketing and claims processing are lost.

7. The role of private insurance companies might be diminished and their profits reduced.

Conclusions: Establishing a Universal Access to Health Insurance Program

The primary advantage of a universal access program would be that all Americans would have specific health insurance benefits and financial access to mainstream health care. In addition to universality and portability, such a program would offer equity in benefits among the states. Substantial cost savings could be achieved compared with current aggregate health insurance costs. A single health insurance program could also alleviate much of the frustration faced by individual practitioners who must now deal with multiple insurance plans and carriers.

A universal access program could include coverage for prenatal, well-child, and other primary and preventive care that could improve the nation's health. Improvements in health could achieve additional savings from increased worker productivity and reduced payments for expenses that now arise from complications of neglected illnesses. A universal access program could alleviate the financial stress on many public hospitals that results from the provision of care to poor and indigent patients for which little or no compensation is now received.

Government administration of Medicare and Medicaid has not been a model of efficiency, nor has it given physicians, hospitals, or other health care providers reason to assume that administrative burdens would be

reduced or that there would be less government interference under an expanded national program. Mechanisms would be needed to assure that the potential administrative savings from adoption of a national insurance mechanism would be allocated to improve or expand health care services.

Conclusions and Recommendations

A National Program Is Needed To Assure Access

All Americans should be able to obtain appropriate health care services, irrespective of age, race, sex, financial status, or place of residence. We believe that assuring access to health care services would achieve improvements in health status, decrease incidence of morbidity and mortality, and, possibly, contribute to increased life expectancy among those groups with the least access to care and the highest, age-adjusted, disease-specific mortality rates.

A multitude of existing programs and mechanisms enables most persons to obtain the health care services that they need. Still, many persons do not have adequate health insurance protection. In addition, rising costs and increasing bureaucratic and administrative burdens of the present system require re-examination. The existing system is inefficient and expensive, and a new approach is required.

We have focused on mechanisms to increase health insurance coverage as a means of improving access to health care services. Six types of broad policy proposals have been identified: the advantages and disadvantages of each have been presented. In view of these criteria, we conclude the following:

A nationwide program is needed to assure access to health care for all Americans, and we recommend that developing such a program be adopted as a policy goal for the nation. The College believes that health insurance coverage for all persons is needed to minimize financial barriers and assure access to appropriate health care services.

Assuring access also involves issues of cost and quality. The medical profession bears responsibility to ensure that acceptable, appropriate, and cost-effective care is delivered.

A nationwide program would establish a coordinated financing mechanism that would assure access to appropriate care for all of our citizens. Public policymakers are urged to initiate action now to accomplish this goal. A national commitment to assure access to health care is essential, because the current situation is resulting in the denial of adequate care to an inordinate number of persons, cost-cutting incentives are beginning to replace medical decision making in determining use and availability of health care services, our current system has excessive administrative costs, and the infrastructure of our health care system is in jeopardy.

The Issue of Administrative Costs and Burdens Must Be Addressed

It appears that substantial savings could be obtained by reducing administrative costs, improving efficiency.

and eliminating wasteful duplication of coverage. Current payment and reimbursement mechanisms in the United States necessitate large bureaucracies and enormous administrative expenses to ensure that each and every service provided by institutions, physicians, and other health care providers is attributed to a specific patient. These expenses occur in commercial and not-for-profit private insurance plans as well as in public programs. There are tremendous costs involved in identifying, billing, collecting, and reviewing payments for services. Private, competitive programs also incur costs for advertising, marketing, profits, and reserves. These administrative costs are borne not only by the insurers and public programs but also by hospitals, physicians, and others.

In contrast to private insurance costs, publicly funded programs do not include costs for profits, marketing, or premium collection. The overhead for the universal public insurance system in Canada currently averages 2.5% of program costs. Overhead costs of Medicare and Medicaid amounted to less than 3% in 1983. Today, with increased Medicare and Medicaid total outlays, these costs are closer to 2%. This figure includes costs for contractor administration, research and demonstration projects, surveys and certifications of facilities, as well as salaries for program administration (2). Additional administrative savings could be achieved under a nationwide insurance program, because there would be no need to determine income or categoric eligibility, as presently required under Medicaid.

With a gross national product (GNP) approaching \$6 trillion, the amounts of money that could be saved by at least stabilizing the rate of growth in U.S. health care spending could be staggering and may indeed be enough to pay fully for the cost of a universal access to health insurance program. Each one-percentage-point reduction in the proportion of GNP now attributed to health care (which includes administrative overhead as well as other costs due to inefficiencies inherent in the system) would yield savings of almost \$60 billion per year.

Criteria Must Be Used To Evaluate Proposals for Reform

The issues concerning problems of access to health care are complex. Any new program to address them on a nationwide basis will have to include consideration of the ramifications of such changes. Caution must be exercised to preserve the strengths of the existing system, such as its ability to foster innovation and achieve advances in medical science, while correcting for its deficiencies. The time has come for a re-examination of the present system and a full examination of possible new approaches. This paper is an attempt to begin that process.

We have discussed development of a comprehensive financing program as one option for assuring access to health care for all Americans. Although we recognize that consideration of this option could be controversial and divisive for the medical profession, we believe that it merits serious examination. We further recognize that there are many major policy issues that would need to be resolved before a nationwide, health insurance fi-

ancing mechanism could be developed for the United States. One central task would be to define clearly the services that would be covered.

We have indicated that a new process for determining the scope of benefits would be required. Such a process must distinguish the clinical role of advising on the appropriateness of specific services from the societal role of determining the feasibility of providing such services. The structure of the program, particularly of the financing mechanism, would be equally important. It must be designed in conformance with agreed upon criteria for a better system. We have offered criteria that might be used.

Payment rates for health care services would need to be sufficient to assure that adequate numbers are attracted to health professions careers. Likewise, sufficient financial resources would need to be devoted to supporting appropriate educational and training programs.

Planning and financing would be required to assure that facilities are kept up-to-date and are available where needed. Investments in research and development would need to be sufficient to enhance scientific knowledge and to achieve further technologic advances. Funding for health services research would be even more critical as greater emphasis would be given to improving the effectiveness and efficiency of the delivery of health care services.

Cost containment and controls to avoid excessive use of services would be necessary under a nationwide health insurance program, as under any health insurance plan. However, such efforts could be based primarily on scientifically valid determinations of medical necessity and appropriateness.

Finally, we re-emphasize the need to minimize costs and dramatically reduce administrative burdens for patients, families, and physicians and other health care providers. Restructuring and reforming the professional liability system are necessary to reduce the cost of medical practice and to encourage appropriate utilization of medical services.

Complex Policy Questions Must Be Discussed and Debated

Unresolved questions to be addressed include how to assure that the manpower, facilities, and services are, in fact, available and how to integrate a new universal-access program with existing public health programs, such as Medicare and Department of Veterans Affairs, community health, and National Health Service Corps programs. How would a nationwide health insurance program affect the availability of private health insurance? A comprehensive and coordinated nationwide program would highlight the need to address many pending questions concerning standards of quality and mechanisms for quality assurance. What controls on utilization would be required? These and other questions will need to be considered.

Issues of Timing, Cost, and Feasibility Require Sound Analysis and Discussion

Much confusion exists concerning the issue of costs of an expanded system. Some have argued that incre-

Appendix 1. Annualized Medicaid Eligibility Thresholds—July 1989

State	AFDC (Family of Three)	Percent of Poverty Level	Medically Needy	Percent of Poverty Level	OBRA 1986-1987 Pregnant Women (Family of Three)	Percent of Poverty Level
	\$	%	\$	%	\$	%
Alabama	\$1,416	14.1%			\$10,060	100.0%
Alaska	9,708	77.2			12,580	100.0
Arizona	3,516	35.0			10,060	100.0
Arkansas	2,448	24.3	\$3,300	32.8%	10,060	100.0
California	8,328	82.8	10,704	106.4	18,611	185.0
Colorado	5,052	50.2			7,545	75.0*
Connecticut	6,660	66.2	8,857	88.0	18,611	185.0
Delaware	3,996	39.7			10,060	100.0
D.C.	4,716	46.9	6,288	62.5	10,060	100.0
Florida	3,444	34.2	4,596	45.7	15,090	150.0
Georgia	4,968	49.4	4,404	43.8	10,060	100.0
Hawaii	7,224	62.4	7,224	62.4	21,405	185.0
Idaho	3,780	37.6			7,545	75.0*
Illinois	4,104	40.8	5,496	54.6	10,060	100.0
Indiana	3,456	34.4			10,060	100.0
Iowa	4,920	48.9	6,600	65.6	18,611	185.0
Kansas	4,920	48.9	5,760	57.3	15,090	150.0
Kentucky	6,312	62.7	3,696	36.7	12,575	125.0
Louisiana	2,280	22.7	3,096	30.8	10,060	100.0
Maine	7,584	75.4	7,092	70.5	18,611	185.0
Maryland	4,752	47.2	5,508	54.8	18,611	185.0
Massachusetts	6,948	69.1	9,300	92.4	18,611	185.0
Michigan	6,900	68.6	6,660	66.2	18,611	185.0
Minnesota	6,384	63.5	8,508	84.6	18,611	185.0
Mississippi	4,416	43.9			18,611	185.0
Missouri	3,420	34.0			10,060	100.0
Montana	4,308	42.8	4,836	48.7	10,060	100.0
Nebraska	4,368	43.4	5,904	58.7	10,060	100.0
Nevada	3,060	30.4			7,545	75.0*
New Hampshire	6,072	60.4	6,900	68.6	7,545	75.0*
New Jersey	5,088	50.6	6,792	67.5	10,060	100.0
New Mexico	3,168	31.5			10,060	100.0
New York	6,468	64.3	8,508	84.6	18,611	185.0
North Carolina	3,192	31.7	4,298	42.7	10,060	100.0
North Dakota	4,632	46.0	5,220	51.9	7,545	75.0*
Ohio	3,852	38.3			10,060	100.0
Oklahoma	5,652	56.2	5,196	51.7	10,060	100.0
Oregon	5,184	51.5	6,900	68.6	8,591	85.4
Pennsylvania	4,608	45.8	5,400	53.7	10,060	100.0
Rhode Island	6,516	64.8	8,700	86.5	18,611	185.0
South Carolina	5,028	50.0			18,611	185.0
South Dakota	4,524	45.0			10,060	100.0
Tennessee	4,644	46.2	3,000	29.8	10,060	100.0
Texas	2,208	21.9	3,204	31.8	13,078	130.0
Utah	6,192	61.6	6,192	61.6	10,060	100.0
Vermont	7,812	77.7	10,500	104.4	18,611	185.0
Virginia	3,492	34.7	4,298	42.7	10,060	100.0
Washington	5,904	58.7	7,188	71.5	18,611	185.0
West Virginia	2,988	29.7	3,480	34.6	15,090	150.0
Wisconsin	6,204	61.7	8,268	82.2		
Wyoming	4,320	42.9			10,060	100.0
Average state	\$4,942	48.6%	\$6,165	61.0%	\$14,617	144.1%

* Complying with federal mandate. AFDC = Aid to Families with Dependent Children; OBRA = Omnibus Budget Reconciliation Act.
Source: National Governors' Association, July 1989.

mental steps are necessary because of cost concerns. Others argue that the efficiencies of a universal system would offset the costs of expanded services. These analyses will need to be examined in greater detail, particularly because they are highly dependent on specific elements in the design of either approach.

Cost and budgetary considerations may necessitate taking an incremental approach to accomplishing the goal of extending health insurance protection to all Americans. One interim step that has already been taken has been to expand Medicaid coverage for some segments of the population and to establish uniform eligibility levels based on percentages of the poverty level. Further improvements could be achieved by establishing uniform Medicaid eligibility levels that would extend coverage to all persons with incomes at or below a predetermined level. Coverage for employed workers and their families could be expanded by requiring employer-based health insurance. However, these should be viewed as interim measures as we continue to explore the need for other changes in the health care delivery system.

A comprehensive and coordinated program to assure access on a nationwide basis is essential. In the near term, given the urgency of the need, it should build on the strengths of existing health care financing mechanisms. In the longer term, careful consideration of new and innovative alternatives, including some form of a nationwide financing mechanism, will be necessary.

The American College of Physicians believes that it is time to confront the issue of access to health care. Piecemeal solutions to a national problem of this magnitude will not suffice. Maintenance of the basic infrastructure for the provision of care in this country is a national priority and must be addressed accordingly. Hence, the problem of access to care must be addressed not only because of the need to assure that services are available to those who are presently uninsured or underinsured, but also as a means of creating a more efficient system for delivering services to all Americans. Reliance solely on private charity or the efforts of individual states—with their differing and variable resources—to assure that the national need is met is a fundamental abrogation of this overarching responsibility. The College is committed to working with its members and others to meet this challenge.

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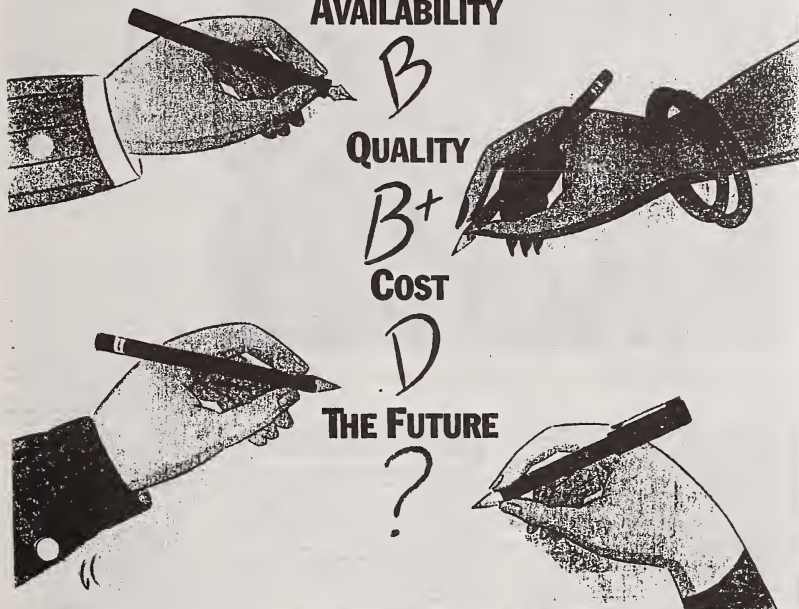
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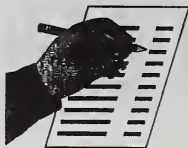
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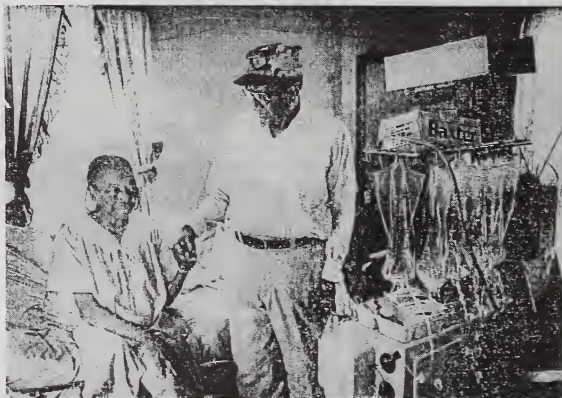
THE FUTURE

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Americans Grade Their Health Care



In Smoaks, S.C., James Mosley, 74, helps his wife Louise, 71, who undergoes kidney dialysis five nights a week, in the trailer home they bought after their house burned down.

Five nights a week, lying in bed inside her trailer in rural South Carolina, Louise Mosley hooks herself up to a machine that saves her life by doing the blood-cleansing work her damaged kidneys no longer can.

Blood circulates out of her body through a tube from her abdomen to the dialysis machine—a series of tubes and filters that draw impurities out before returning the blood to her body. Louise Mosley has been on kidney dialysis since diabetes caused her kidneys to fail more than 10 years ago, and her right leg was amputated this year because of infection and poor circulation.

Social Security pays most of the cost of kidney dialysis, which can reach several thousand dollars a month.

But when Mosley, 71, goes to the drugstore twice a month to buy medicine, neither Social Security nor Medicare covers the purchases. Insulin pills, dialysis pills, kidney pills, pain pills, pills to soothe her digestive tract—she said she spends about \$100 a month on doctor-prescribed drugs. Her husband, James Mosley, 74, a retired construction worker, also requires

medicine to control his blood pressure.

Louise and James Mosley have lived in a trailer outside of Smoaks, S.C., about 70 miles west of Charleston, ever since their home on the same site burned to the ground five years ago.

"Everything we had burned up with it," said Louise Mosley, who fled the burning house in a housecoat. "We didn't save a rag of clothes."

With the insurance settlement of \$8,000, the Mosleys replaced some clothes and household necessities and made the \$8,000 down payment on their trailer, on which they still owe \$188.22 a month, not counting insurance.

The Mosleys' only income is their combined Social Security pension of about \$900 a month—\$650-plus a month for James and \$200-plus a month for Louise. That is barely enough to meet their needs—but it's enough to disqualify them from coverage under Medicaid, the federal-state program of health insurance for the poor.

—Don Colburn

By Don Colburn
and Richard Morin
Washington Post Staff Writers

Most Americans are satisfied with the quality and availability of their health care, but anxieties about cost prompt an overwhelming majority to favor key changes in the health insurance system, a nationwide Washington Post-ABC News poll shows.

Three out of four of those surveyed favor efforts to expand health insurance either by requiring businesses to provide coverage to all employees or by a national health care plan run by the government and financed by taxpayers.

The poll indicates a potential political constituency for health care issues in the upcoming election year. An overwhelming majority—83 percent—said a candidate's position on health care will be an important factor in determining how they vote in next year's presidential election.

Eleven percent called health care the most important issue in the campaign, and an additional 72 percent said it would be one of several important issues.

Interest in health care issues is strongest among women, blacks and older Americans. Those 61 and older are more than twice as likely as those between 18 and 45 to see health care as the single most important issue in the election; poor people are three times as likely as the affluent to do so, blacks twice as likely as whites to do so, and women half again as likely as men.

The mixed feelings Americans have about the health care system are clear from the divergence of opinion about its quality, availability and cost.

■ On quality, 75 percent expressed satisfaction, while only 24 percent said they are not satisfied.

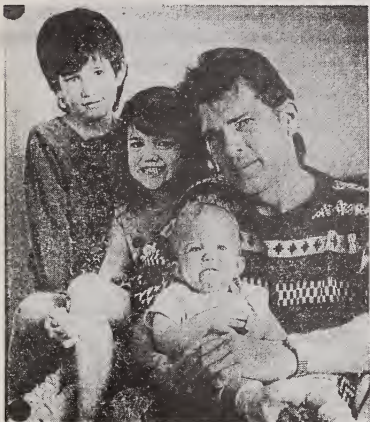
■ On availability, 71 percent are satisfied, while only 28 percent are not.

■ On cost, 36 percent are satisfied, while 64 percent—nearly two out of three—are not.

"There's real concern about cost out there," said Jack A. Meyer, president of New Directions for Policy, a private independent economic consulting and research firm specializing in health care issues. "But there's more consensus about what people don't want than what they do want."

"Reform looks real good until you start talking about specifics."

Because there are "no painless solutions,"



In Keller, Tex., Marty Kane, 34, a self-employed landscaper, has postponed around surgery until he can save enough money from his seasonal work. Meanwhile, he helps save child care costs by staying home in the off season with Brandon, 7, Courtney, 5, and Athena, 1, while his wife Regina is at work.

Marty Kane hopes the work gets better before his infection gets worse. Kane, 34, of Keller, Tex., is counting on his highly seasonal landscaping job picking up by late winter, so that he'll have time to sock away enough money to pay for the surgery he needs to allow him to keep working. Kane has an internal infection that has caused a painful sore and abscess near the rectum. The abscess makes it difficult to go to the bathroom and, on the worst days, causes back pain that keeps him from working his landscaping business, where he is on his feet for long days. The condition flared up more than three years ago, and Kane had surgery to clean out the infection and drain the abscess. At the time, he received health insurance through his employer, a small company specializing in emergency chemical cleanup of hazardous waste. When the company was bought out and closed in 1989, Kane decided to go into business on his own as a maintenance worker and landscaper. The operation relieved Kane's condition for a while, but now the infection has flared up again, even worse than before. The infection has eaten a hole in the wall of his lower intestine, creating an abnormal drainage called a fistula, and he needs another operation to repair the damage. But the fistula surgery would cost between \$4,000 and \$4,500 in hospital and doctor's fees alone, not counting anesthesia or follow-up care. And Kane, as a self-employed worker, has no health insurance coverage. Kane's wife, Regina, is a computer specialist with a job placement company, which pays for her health insurance. But the couple cannot afford the additional \$230 per month that it would cost to bring Marty Kane and their three young children under her health plan. The Kanes live in an apartment in Keller, about 16 miles north of Fort Worth. During the winter months, when the landscaping business comes to a virtual halt, Kane mostly stays at home with the children—ages 7, 5 and 1—which saves about \$80 a month in child care expenses. "I hope now is that when his landscaping work revives in the spring, he can make enough money by summer to afford the extra premium that will provide coverage under his wife's health insurance plan. Then, he'll go ahead and have the fistula surgery and try to get back to work within six weeks or so to pay the bills. "I need the operation now," he said. "I just can't afford it. I hope I can make enough to get the surgery pretty soon—before it turns into an emergency."

—Don Colburn

The poll indicates a potential political constituency for health care issues in the upcoming election year. An overwhelming majority—83 percent—said a candidate's position on health care will be an important factor in determining how they vote in next year's presidential election.

Meyer said, the health care issue poses a dilemma for politicians. "If you go and give a speech railing about health care costs, you get a lot of applause. I know—I've done it. But as soon as you start talking about what might be done to control those costs, that tends to quiet the audience—if not clear the room."

The real source of rising medical costs, he said, is that "we have an aging society; exploding technology, high expectations and a medical malpractice system that's ready to sue the pants off any doctor who doesn't do everything possible in every case."

In a time of recession, Meyer said, people are particularly anxious about loss of health care benefits, which could leave them "in a free-fall without a parachute."

Thirty-one percent of those polled said they or a member of their family had postponed getting medical care during the past year because it might cost too much. Of those, most called the illness or condition "not too serious," but two out of five said it was "fairly serious" or "very serious." Respondents from families with incomes under \$20,000 were twice as likely as those with incomes above \$50,000 to say medical care had been postponed because of cost.

■ ■ ■

A couple of years ago, the little bump on Mary Treen's left hand started to grow and look unsightly. Instead of having it removed by surgery, she put off the operation because she had no health insurance and couldn't afford the estimated \$4,500 cost—especially since the bump appeared to be a harmless cyst and didn't hurt.

"I put it off a year and a half," said Treen, 26, of Simi Valley, Calif. "They thought it was just a cyst, and the surgery would have cost \$2,000 for the surgeon, plus \$2,500 in hospital bills. It cost \$150 to go to the hand surgeon—just to see him."

Treen finally had the cyst removed this past August, after obtaining health coverage through her new job as an accounting clerk. The "harmless" cyst turned out to be a rare form of bone cancer, and she had to have follow-up surgery to remove more tissue, as well as radiation and physical therapy.

At the time she delayed the surgery, Treen had a baby daughter and was unemployed. Her husband, a computer programmer at a three-person company, was not covered by his employer. Today, she is covered by her employer and pays an additional \$120 a month to cover her husband and daughter.

Now Treen's medical bills have totaled close to \$25,000, including about \$5,000 not covered by her insurance policy. She said her doctors believe they have removed or irradiated the cancerous tissue in time to prevent further spread.

But prompt surgery might have saved her thousands of dollars—and untold anxiety.

"If I had had it taken care of right away," Treen said, "it might not have turned to cancer." She said a pathologist told her that while it could not be proven, the cyst was probably benign a year and a half ago.

■ ■ ■

While a majority of those polled—57 percent—said they are "confident that my major health care costs would be taken care of" if they had a serious accident or illness today, that confidence erodes when the future is broached. 68 percent are worried that future health care costs "will not be taken care of."

And about a quarter of those polled said they or a member of their household had decided in the past two years to stay in one job rather than take a new one mainly because it offered better health care benefits.

More than a third said their employer has cut back on health benefits or made workers pay a higher percentage of health insurance costs in the past two years. A roughly equal number said their employer has not cut benefits. The rest said they were unemployed or self-employed or received no health benefits through their employer.

Among those whose employers have not cut benefits, nearly two thirds said they are not worried at all or "not too worried" about having benefits cut or having to pay a higher percentage of health care costs. The remaining third said they were worried.

Asked whether they think they have adequate insurance or other sources of money to pay for long-term nursing home care if they become permanently disabled from illness, accident or old age, most said "no." A total of 77 percent said they lacked such insurance or other financial resources.

Dissatisfaction with the cost of medical care is highest among middle-aged Americans. Dissatisfaction with both quality and availability of care is highest among those with incomes of less than \$12,000 a year; satisfaction is highest among people earning more than \$50,000 a year.

The findings are based on a national telephone survey of 1,512 randomly selected adults conducted Dec. 11-15. The margin of

See POLL, Page 9

THE WASHINGTON POST/ABC NEWS POLL

In the next presidential election, how important will a candidate's position on health care be in determining your vote? Is it the most important single issue, is it one of several important issues, or won't it have much influence on your decision?

Single most important issue	11
One of several important issues	72
Won't have much influence on decision	16
No opinion	1

On another subject, have you ever heard of a living will?

Yes	81
No	19

Do you personally have a written living will that states what should be done in case you have a terminal illness or injury, with no hope of recovery?

Yes	17
No	83

Asked of those who do not have a living will: Have you seriously discussed with a family member, close friend or someone else what you would want done if you suffered from a terminal illness or injury and were in no condition to make such decisions yourself?

Yes	58
No	42

How satisfied are you with the cost of health care you receive?

Satisfied (total)	36
Very satisfied	10
Generally satisfied	25
Not satisfied (total)	64
Not so satisfied	25
Not satisfied at all	37
No opinion	1

How satisfied are you with the availability of health care you receive?

Satisfied (total)	71
Very satisfied	27
Generally satisfied	45
Not satisfied (total)	28
Not so satisfied	16
Not satisfied at all	11
No opinion	1

How satisfied are you with the quality of health care you receive?

Satisfied (total)	75
Very satisfied	26
Generally satisfied	49
Not satisfied (total)	24
Not so satisfied	14
Not satisfied at all	10
No opinion	1

Do you agree or disagree with the following statement: If I had a serious accident today or was told I have a serious illness, I am confident that my major health care costs would be taken care of.

Agree	57
Disagree	42
No opinion	1

And do you agree or disagree with this statement: I worry that health care costs I may have in the future will not be taken care of.

Agree	58
Disagree	31
No opinion	1

Which of the following three approaches to financing health care would you favor:

A health care plan that requires businesses either to provide coverage for all their employees or contribute to a federal fund that would cover all employees? 32

A national health care plan run by the government, financed by the taxpayers, which would cover all Americans? 44

Maintain the current system of private insurance Medicare and Medicaid? 20

No opinion 3

In the past year, have you or a member of your immediate family postponed getting medical care because you thought that it might cost too much?

Yes	31
No	69

Asked of those who postponed medical care: When you postponed this medical care, was the illness or condition not too serious, fairly serious or very serious?

Not too serious	59
Fairly serious	27
Very serious	13
No opinion	1

In the past two years, have you or a member of your household decided to stay in one job rather than take another job mainly because it offered better health care benefits for you and your family?

Yes	24
No	67
No one in household works	8
No opinion	1

If you work, in the last two years has your employer cut back on health benefits or made you pay a greater percentage of health insurance costs?

Yes	34
No	37
Don't work	20
No health benefits through employer	4
Self employed/employer	3
No opinion	1

Asked of people whose employers have not cut benefits: How worried are you that your employer will cut back on health benefits or make you pay a greater percentage of the health care costs:

Worried (total)	34
Very worried	11
Somewhat worried	24

Not worried (total)	64
Not too worried	28
Not worried at all	36
No opinion	2

What if you became permanently disabled from disease, an accident or old age and required care in a nursing home facility for the rest of your life? Do you think you have adequate insurance or other sources of money to pay for such care, or not?

Yes	21
No	77
No opinion	2

These figures are from a Washington Post-ABC News telephone poll of 1,512 randomly selected adults nationwide conducted Dec. 11-15, 1991. Margin of sampling error is plus or minus 3 percentage points overall. Interviewing was conducted by Chilton Research of Radnor, Pa.



Lombard, Ill., Marian McGuire, 35, holds son Byron, 2½, who was born nine weeks early with lung problems that led to expensive treatments totaling nearly \$1 million. Until recently, Byron's father Kevin was unable to switch jobs because other employers' insurers refused to accept Byron for coverage although his condition has improved steadily.

When their son Byron was born nine weeks premature in July 1989, everything changed for Marian and Kevin McGuire, a suburban Chicago couple. Fortunately, they had good health insurance through their jobs with a Chicago computer firm. Because he was born so early, Byron's lungs were not fully developed, and he had respiratory problems that required him to spend the first 3½ months in the intensive care unit. During his first year, he returned to the hospital for three long stays and in between those hospitalizations was in and out of the emergency room about once a month because of chronic difficulty breathing. The whole time, he had to be given oxygen through a tube to help him breathe.

Byron is now 2½, his lungs steadily strengthening and his breathing problems less frequent. His seldom needs extra oxygen these days. But he is still especially vulnerable to lung infections and for that reason can't yet go to regular group day care.

At the time Byron was born, Kevin McGuire wanted desperately to change jobs. But suddenly, no prospective employer would agree to cover Byron under his insurance plan.

"No one would touch Byron with a 10-foot pole," said Marian McGuire.

"Everywhere Kevin went, they said forget it. Or at best, maybe in a year."

"With our bills, we couldn't have somebody saying maybe."

Byron's parents estimate that his total medical bills have reached \$1 million in just 2½ years. Most but not all has been paid by his parents' employer-provided insurance plan.

Insurance companies are increasingly unwilling to take on prospective policyholders who are known to have illnesses or conditions that require costly treatment. "It's our little pre-existing condition," joked Marian McGuire about her son, using the insurance industry's technical term for such illnesses.

Finally, this month, Kevin McGuire did switch jobs, his new employer agreeing to cover Byron within one year. He had to take a cut in pay to get that coverage.

Now, it is Marian McGuire's turn to feel the pressure. To keep the family's health insurance, she had to upgrade her job to "permanent part-time," and now she cannot quit or move or cut back her hours—or spend as much time as she wishes with Byron—for at least a year, until her husband's insurance takes effect.

"You really do feel trapped," she said. "All your decisions are based on insurance." And yet, she knows they are among the lucky. When a medical crisis struck, she and her husband had adequate insurance. They both have jobs. And their son is healthier by the week.

"When you sit in that ICU and see all the other parents without insurance, you know what it could be like. All of that can be erased so quickly."

—Doe Colburn

POLL, From Page 7

sampling error in the poll is plus or minus 3 percentage points, which means that a finding of 50 percent answering "yes" on any question could reflect an actual total of anywhere from 47 percent to 53 percent.

Berry Aaron, director of economic studies for the Brookings Institution, said the evidence of concern about health care is not surprising but hard to interpret. "The hard question is: What are people making of this? Do they have a general idea of what 'doing something about the system' really means? Are they prepared to pay higher taxes and accept restrictions on care? My sense is that the general answer is no."

Will the issue play an important role in the upcoming election, as it did in the recent Pennsylvania Senate race in which Harris Wofford upset former U.S. Atty. Gen. Dick Thornburgh with a call for health care for all? Aaron said it will depend on the political astuteness of the two parties. If the Democrats bog down in political infighting and nitpick the details of one another's health proposals before the public has a sense of the broad alternatives for reform, he said, they'll be handing the issue back to President Bush.

On the question of restructuring the health care financing system, 44 percent in the Post-ABC poll recommended a national health care plan run by the government and financed by taxpayers. An additional 32 percent recommended requiring businesses either to cover all their employees or contribute to a federal fund that would do so. Twenty percent favored the status quo—a largely private insurance system along with the government programs of Medicare and Medicaid for the elderly, the disabled and the poor.

Self-described conservatives are nearly twice as likely as self-described liberals (29 percent, compared with 15 percent) to recommend maintaining the current system, while liberals were more likely than conservatives to favor a national, tax-based health care plan. Support for employer-based coverage is quite consistent—about one third—across all groups, regardless of region, party affiliation, political ideology, religion or union membership.

Age, however, appears to affect support for the options. People 61 and older are twice as likely as those between 18 and 30 to support the status quo in health care financing. The age difference in those supporting employer-provided insurance was even greater: 42 percent of those 18 to 30 advocated that approach, compared with only 16 percent of those 61 and older. Support for a national health plan did not vary much by age, gender, race, income or education—ranging between 40 and 50 percent across those categories.

The poll indicates that only about one in six Americans has a written living will specifying what kind of treatment they want—or don't want—if they have a terminal illness or injury, with no hope of recovery. Among those 61 and older, it's nearly one in three. But among the majority who don't have a living will, most said they had "seriously discussed" with a relative or friend what they want done if they are in no condition to make medical decisions for themselves.

Coming Wednesday, Jan. 1

What's In, What's Out

Start the year with Style's annual List. It's the "in" thing to do.

Coming Thursday, January 2

What's Hot, What's Not

The Washington Home section's annual listing

Coming Friday, January 3

Names on the Map

You probably know something about the people for whom RFK stadium, the Hoover building and Dulles airport were named. But who was Langley? And how about some of the other names that grace places hereabouts? See the Weekend section.

Coming Sunday, January 5

West Meets East

No stranger to the complexities of race and prejudice in his native land, a black American sets out to examine those issues in Japan—and finds a culture of bias very different from our own. A Washington Post Magazine cover story by Juan Williams.

Coming Sunday, January 5

Sex and a Single Neighborhood

What would you do if someone opened a porn store down the street from your quiet, suburban house? Think it couldn't happen? See David Pridel's story in The Washington Post Magazine.

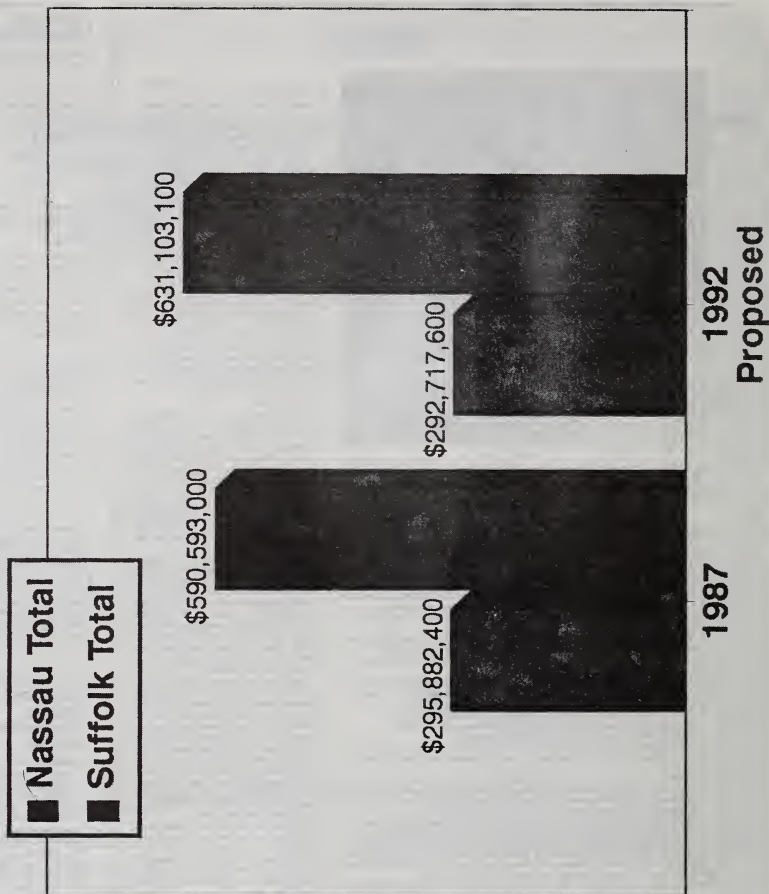
Coming Sunday, January 5

European Unity and the Transatlantic Traveler

Americans going to Europe in the '90s may find some of the romance of the journey gone, but many of the hassles will disappear as well. For example: Look for an end to multiple-currency confusion, more airline competition and lower fares; the chunnel, high-speed rail lines, regional computer link-ups for hotels, fewer delays, fewer border checks. Read all about it in the Travel section's Fearless Traveler column.

Also this week: The singular joys of traveling alone. And a visit to Red Cloud, Neb.—and the lost-looking prairie town Wills Cather wrote about.

Medicaid Expenditures, Federal, State and Local Nassau and Suffolk Counties



Changes in Medicaid Expenditures in Suffolk County 1987 - 1992

(Gross Dollars)

	1987 Actual	1992 Projected	Dollar Change	Percent Change
SNF/ICF	\$114,518,096	\$245,415,170	\$130,897,074	+114.3%
Hospitals	86,586,821	184,283,068	97,696,247	+112.8%
PCA, HHA, Home Nursing	27,288,633	67,779,272	40,490,639	+148.4%
Dr.'s, Clinics & Dentists	17,152,699	43,513,824	26,361,125	+153.7%
Pharmacy & Supplies	13,215,948	28,830,294	15,614,346	+118.1%
Other Practitioners	4,807,776	17,582,274	12,774,498	+265.7%
Transportation	7,085,418	13,572,955	6,487,537	+ 91.6%
All Other*	\$22,062,260	\$30,126,311	\$8,064,051	+ 36.6%
Total Suffolk County				
Medicaid Expenditures	\$292,717,651	\$631,103,168	\$338,385,517	+115.6%

Source: Suffolk County Department of Social Services.

SNF = Skilled Nursing Facility
ICF = Intermediate Care Facility
PCA = Personal Care Aide
HHA = Home Health Aide

* Includes case management, EMO services, laboratory and x-ray services, eyeglasses, prostheses, therapists, institutional child care, rehabilitation and hospice services, retroactive adjustments and Medicare Part B Buy-Ins.

Changes in Medicaid Expenditures in Nassau County 1987 - 1992

	1987 Actual	1992 Proposed	Change	Percent Change
SNF/ICF	\$154,345,135	\$271,270,000	\$117,024,865	+ 75.8%
Hospitals	76,028,035	150,858,000	74,829,965	+ 98.4%
Personal Care	34,359,295	98,250,000	63,890,705	+195.9%
Pharmacy	11,177,380	22,557,000	11,379,620	+101.8%
Doctors and Dentists	7,408,624	18,732,000	11,323,376	+152.8%
Transportation	4,264,820	12,941,000	8,676,180	+203.4%
All Other	\$8,299,136	\$15,885,000	\$7,585,864	+ 91.4%
Total	\$295,882,425	\$590,593,000	\$294,710,575	+ 99.6%

Source: Nassau County Department of Social Services.

SNF = Skilled Nursing Facility

ICF = Intermediate Care Facility

PREPARED STATEMENT OF CHARLES H. MOHAN, STAFF ORGANIZER, DISTRICT COUNCIL
1707, AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, AFL-CIO

HEALTH CARE IS A HUMAN RIGHT AND NOT A PRIVILEGE. IT SHOULD BE AVAILABLE TO ALL AMERICANS. OUR PRESENT HEALTH CARE SYSTEM IS INADEQUATE. DESPITE THE UNITED STATES SPENDING MORE MONEY ON HEALTH CARE EVERY YEAR ("APPROXIMATELY \$2 BILLION A DAY"), NEVERTHELESS, 37 MILLION AMERICANS WERE UNINSURED, AND MILLIONS MORE UNDERINSURED IN 1990. IT IS PROJECTED THAT THESE FIGURES WILL MULTIPLY AND REACH CATASTROPHIC PROPORTIONS, IF THIS SYSTEM CONTINUES.

WHO SUFFERS THE MOST? IT IS ESTIMATED THAT "TWO-THIRDS OF THE UNINSURED ARE WORKING PEOPLE" WHO HAVE NO BENEFITS. IT IS OF PARAMOUNT IMPORTANCE TO WORKERS WHO HAVE SOME BENEFITS, AND ARE THREATENED AT THE BARGAINING TABLE WITH DRASTIC CUTS IN THESE BENEFITS. "HEALTH CARE WAS THE PRIMARY ISSUE FOR 78% OF STRIKING WORKERS IN 1989". EMPLOYERS HEALTH CARE COST ARE "RISING ABOUT 20% A YEAR", AS A RESULT WORKERS' BENEFITS ARE REDUCED.

THE UNEMPLOYED AND POOR HAVE NO ALTERNATIVES. MANY ARE FORCED TO REMAIN AT HOME, RATHER THAN SEEK MEDICAL ATTENTION AT HOSPITALS. "ONLY 40% OF THE POOR ACTUALLY RECEIVE MEDICAID".

THERE ARE "OVER 9 MILLION CHILDREN HAVING NO HEALTH COVERAGE", THEY TOO SUFFER, ALONG WITH OUR ELDERLY, WHO ARE OFTEN TIMES FORGOTTEN. WITH THE EVER INCREASING ATTACKS ON MEDICAID AND MEDICARE, OUR ELDERLY WITH FIXED INCOMES ARE FINDING IT INCREASINGLY DIFFICULT TO PAY FOR NECESSARY MEDICAL ATTENTION. "MEDICARE COVERS ONLY HALF OF THE ELDERLY'S HEALTH CARE COST".

AND WHAT IS MORE FRIGHTENING AND HUMILIATING, THAN BEING REFUSED TREATMENT BECAUSE YOU HAVE NO INSURANCE COVERAGE OR NO MONEY TO PAY FOR THE SERVICE.

WE MUST CHANGE THE PRESENT DETERIORATING SITUATION. NO LONGER SHOULD OVER 1,500 INSURANCE COMPANIES DETERMINE WHETHER AMERICANS ARE ELIGIBLE FOR BENEFITS. WE NEED TO RESHAPE THE ENTIRE HEALTH CARE SYSTEM.

- 2 -

THIS IS WHY DISTRICT COUNCIL 1707 OF AFSCME FULLY SUPPORTS AND ENDORSES THE UNIVERSAL HEALTH CARE ACT H.R. 1300, SUBMITTED BY MARTY RUSSO (D-ILLINOIS). IT IS THE MOST COMPREHENSIVE, WORKABLE AND SENSIBLE PLAN SUBMITTED TO RESCUE THE AMERICAN PEOPLE FROM THE ESCALATING HEALTH CARE COST.

WE THINK IT IS THE BEST PLAN BECAUSE IT OFFERS:

- ONE PROGRAM FOR EVERYONE.
- GUARANTEES FREEDOM TO CHOOSE DOCTORS AND HOSPITALS.
- IT CONTROLS HEALTH CARE COST BY NEGOTIATING FEES WITH HOSPITALS AND DOCTORS.
- A PUBLIC INSURANCE SYSTEM IS ESTABLISHED.
- THERE ARE NO OUT-OF-POCKET COST TO THE INDIVIDUAL REPLACED BY A COMBINATION OF CORPORATE, PAYROLL AND INCOME TAXES.
- ELIMINATION OF WASTEFUL ADMINISTRATIVE COST.
- QUALITY REFORM.

ACCORDING TO OUR STUDY* WHICH OUR UNION CO-SPONSORED, IF SUCH A SYSTEM WAS IMPLEMENTED IN 1991, IT WOULD HAVE SAVED STATE AND LOCAL GOVERNMENTS NEARLY \$30 BILLION. "THE RISING COST OF HEALTH CARE WAS THE SINGLE MOST IMPORTANT CAUSE OF THE DEFICITS" INCURRED BY STATE AND LOCAL GOVERNMENTS, IN 1991. THE STUDY CONTINUED TO SHOW THAT THE SINGLE PAYER SYSTEM WOULD "PROVIDE RELIEF TO STATE AND LOCAL GOVERNMENTS".

"FOR EXAMPLE", IF H.H. 1300 HAD BEEN FULLY IMPLEMENTED IN 1991, STATE AND LOCAL GOVERNMENTS WOULD HAVE SAVED \$5.7 BILLION ON MEDICAID SPENDING, \$38.2 BILLION ON CARE FOR UNINSURED PERSONS, AND \$11.3 BILLION ON EMPLOYEE BENEFITS".

* STUDY WAS DONE BY AFSCME
PUBLIC CITIZENS HEALTH RESEARCH GROUP
PHYSICIANS FOR A NATIONAL HEALTH PLAN

- 3 -

THIS SINGLE PAYER SYSTEM WILL ELIMINATE THE UNNECESSARY STRESS ON AMERICANS WHO USUALLY FEEL "I CAN'T AFFORD TO GET SICK". UNDER THIS PLAN, AMERICANS WILL RECEIVE PROPER HEALTH CARE, WHICH WILL ADD TO LONGEVITY, AND A HEALTHIER AMERICA. A HEALTHY AMERICA IS A MORE PRODUCTIVE AMERICA.

WE, THEREFORE, URGE ALL OUR POLITICAL REPRESENTATIVES ON THE STATE AND FEDERAL LEVELS TO SUPPORT THIS BILL.

**MEDICAL SOCIETY
OF
THE STATE OF NEW YORK**

**Proposal for
Improving the U.S. Health Care System**

**420 Lakeville Road • P.O. Box 5404 • Lake Success, NY 11042 • (516) 488-6100
One Commerce Plaza • Suite 2005 • Albany, NY 12210 • (518) 465-8085**

INSURING THE UNINSURED
CREATING AN AMERICAN UNIVERSAL HEALTH CARE SYSTEM

The Medical Society of the State of New York has created a potential mechanism to assure that all citizens are fairly and adequately covered for their basic health care needs.

First, our plan calls for a federal law mandating that an appropriate health benefits package be made available by all health care insurance entities. The law would also mandate that such a package be purchased for each individual American citizen, either by the individual, or voluntarily by his or her employer. This basic package would be uniform across the country and would cover everyone, no matter what their age or income level. Competition between insurance companies would force competitive pricing of premiums.

Our program is based on the fact that the US has a large, superbly trained physician population, dedicated and skillful nurses, technicians, midwives, therapists and other health care professionals. Our hospitals are first-rate, and our medical schools are well-equipped and superbly staffed. If we are to find a solution to the glaring weaknesses of the US health care system, we must maintain and build upon these systemic strengths.

But even with excellent facilities Americans who leave their current jobs, lose -- at least temporarily -- their health care coverage. Furthermore, so-called preexisting conditions may be excluded from any new policy provided by their next employer. Or they could find themselves in a

position with an employer who does not provide health insurance at all. Rarely are employer-provided plans transportable to new jobs. Our program would assure that these individuals would have continuous coverage. Estimates are that 31 million Americans are without health care insurance, and an additional 70 million have inadequate insurance.

No American would be left out of the national basic benefits system. This means that even the high insurance risk patient would be covered. Under the Medical Society plan insurance companies would be required to cover these persons as part of their franchise to sell the basic benefits package. A risk-pooling formula would be established that would spread the risk equally among all insurers.

How would we pay for this care in a fair and equitable manner? The best method to accomplish that goal is to utilize the graduated income tax system. In our proposal, health care insurance would become a credit against taxes, dependent upon income.

Americans in the highest tax brackets would be considered able to afford the basic health care benefits package without public assistance. Their tax credit would be zero. Americans in lower tax brackets, however, would gradually be given greater and greater aid in purchasing the basic package. Their tax credits would be determined on a sliding scale. They would be allowed to apply a larger and larger credit toward their income tax.

Employers would be encouraged to purchase the appropriate health benefit package for their employees as an inducement to attract high quality workers. The cost of the package, however, could be considered taxable income to each individual employee. The employee, thus, would retain the tax credit.

When the tax base reaches the truly indigent, who cannot and do not pay any tax at all, the health care insurance tax deduction is replaced with a non-transferable, one-use-only voucher usable solely to purchase the basic benefits health care package. The tax system gives the government a simple mechanism to determine who needs what help with the purchase of this insurance.

This system would mean that most Americans would pay some portion of their basic health care coverage, according to their ability to do so. In order to discourage frivolous overutilization of the system, a coinsurance and deductible would be required except for those Americans deemed truly indigent.

Quality would be assured in the new system, along with economy and efficiency. We envision two main safeguards to do this. First, the establishment of appropriate medical review with the meaningful participation of qualified physicians at the state and local levels to assure the medical necessity and quality of all care rendered. Second, through the use of frequency of services parameters, arrived at in meaningful consultation with physicians and other providers.

We see no parallel for this approach anywhere in the world -- and that is how it should be. The United States is not Canada, not Great Britain, not France or Germany. An American Universal Health Care System must employ American strengths, American values. The technical wonders of health care in this nation have long been the envy of the world. By applying ourselves to curing the social ills that weaken our ability to deliver that best quality health care to all our citizens, we will once again light a path for other societies to follow.

THE HEALTH POLICY AGENDA
FOR THE AMERICAN PEOPLE

**A RECOMMENDED
BASIC BENEFITS PROGRAM**

OUTLINE OF THE HPA BASIC BENEFITS PACKAGE

A. Prevention and Health Promotion

1. Maternal and child care, including medical examination of the mother before and after the birth of a child.
2. Immunizations where they are health and cost effective.
3. Medical examinations on a periodic basis according to age, sex and health history for early discovery of potentially serious illness.

B. Care of Current Physical and Mental Problem

1. Semi-private room and board in a hospital, and related basic services:
 - diagnostic services
 - X-ray and laboratory services
 - emergency room services and supplies
 - radiation/chemotherapy
 - anesthesiology services
2. Services of physician, including surgeon, in and out of hospital
3. Physical, occupational and speech therapy prescribed by a physician
4. Mental health diagnosis and treatment including substance abuse (drug and alcohol)
5. Short term home care and/or care in a skilled nursing facility where it is health and cost effective
6. Hospice care in the home in the case of terminal illness

C. Long-term Care (chronic)

1. Home care services of skilled nurses, physicians and other practitioners
2. Skilled nursing facility care, including room and board and necessary services, as a substitute for hospitalization where home care is not feasible

DETAILED BENEFITS PACKAGE**CATEGORY A SERVICES:**
PREVENTION AND EARLY IDENTIFICATION**I. MATERNAL & CHILD CARE**

1. Medical examination of mother before birth of child (Pre-natal)
2. Medical examination of mother after birth (Post-natal)

II. IMMUNIZATIONS

1. Immunizations of appropriate ages that are health and cost effective

III. MEDICAL EXAMINATIONS

Procedures designed for early identification of potentially serious problems. (Routine physicals are not covered.)

- Under age 40: once every five years
- Ages 40-49: once every three years
- Age 50 and after: once a year

CATEGORY B SERVICES:
TREATMENT OF PHYSICAL AND MENTAL ILLNESS (ACUTE CARE)**I. DIAGNOSTIC AND TREATMENT SERVICES IN THE OFFICE OR OTHER OUT-OF-HOSPITAL SETTING**

1. Diagnostic services by physician, including initial consultation and second opinion initiated by patient or physician
2. Medical or surgical treatment of illness or injury
3. X-ray and lab services
4. Mental health therapy by licensed and/or certified physician or other appropriate professionals:
 - Assessment and diagnosis
 - Treatment up to 50 visits per calendar year
5. Substance abuse (drugs and alcohol) treatment by licensed and/or certified practitioners
6. Radiation and chemotherapy
7. Physical, occupational and speech therapy prescribed by a physician

II. EMERGENCY AND HOSPITAL OUTPATIENT SERVICES

1. Physician services*
2. Operating room and supplies/equipment*
3. Emergency room and supplies/equipment*
4. Facilities charge*
5. Diagnostic services, including X-ray and lab*
6. Physician prescribed outpatient physical, occupational and speech therapy*
7. Radiation and chemotherapy*
8. Mental health services:*
 - Assessment and diagnosis
 - Treatment, up to 50 visits per calendar year

*Subject to appropriateness review

III. INPATIENT CARE - HOSPITAL AND REHABILITATION FACILITY SERVICES FOR PHYSICAL AND MENTAL ILLNESS

1. Semi-private room and board, including related basic services*
2. Diagnostic services**
3. Physician visits and services, including surgery***
4. Physical/occupational/speech therapy****
5. Radiation and chemotherapy*****
6. Rehabilitation unit charges*****
7. Medication /blood/biologicals/supplies/appliances/equipment
8. Operating/delivery/recovery room charges
9. Substance abuse: detoxification only, including one readmission per calendar year
10. Mental health: professional visits and related services, 30 days per calendar year*****

*Subject to admission review; pre-certification will be used selectively along with specified second opinions

**Diagnostic services subject to admission review; pre-admission testing wherever practical

***Frequency of visits subject to external appropriateness review

****Only covered where these services cannot be provided on an outpatient basis

*****Admission subject to pre-certification; outpatient services are encouraged

IV. HOSPICE CARE - HOME SETTING

1. Intermittent nursing*
2. Continuous nursing (on a 24 hour basis)**
3. Physician visits***
4. Oxygen/blood/supplies/medications as prescribed

*Subject to physician approval

**Subject to physician approval

***Frequency subject to review/case management

V. HOME CARE - HOME HEALTH CARE - SHORT TERM*

1. Skilled nursing care - up to 30 visits
2. Physician visits
3. Medical equipment and biologicals
4. High technology services
5. Physical, occupational and speech therapy
6. Medications
7. Durable medical equipment

*Home health care is recommended as an alternative to hospitalization wherever feasible given physical, mental and environmental circumstances. All home care is subject to formal, written treatment plan prepared by physician. Length of treatment and frequency of visits based on diagnosis and subject to utilization review.

VI. SKILLED NURSING FACILITY (SNF) - SHORT TERM*

1. Room and board - up to 45 days
2. Skilled nursing services - up to 45 days
3. Physician visits**
4. Medical equipment and supplies
5. Physical, occupational and speech therapy

*SNF is to be used as a substitute for hospitalization when appropriate. Admission is to be based on diagnosis, prognosis, and formal written treatment plan.

**Subject to review

CATEGORY C SERVICES: **CHRONIC CARE**

I. HOME CARE - LONG TERM*

1. Skilled nursing services up to 90 visits**
2. Physician visits***
3. Medical equipment and supplies

*The home setting is generally the preferred site for chronic care.

**Subject to appropriateness review and used as offset to hospitalization.

***Subject to appropriateness review.

II. SKILLED NURSING FACILITY*

1. Room and board up to 90 days**
2. Skilled nursing services***
3. Physician visits***
4. Medical equipment and supplies

*The home setting is the preferred site for chronic care.

**Used as an offset to hospitalization and where home care is not feasible.

***Subject to appropriateness review.

TESTIMONY SUBMITTED TO
SUBCOMMITTEE ON HUMAN SERVICES
U.S. HOUSE OF REPRESENTATIVES

CONCERNING
THE RUSSO NATIONAL HEALTH INSURANCE PROGRAM ACT (HR-1300)

by

Ruth A. Brandwein, Ph.D.
Commissioner, Suffolk County Department of Social Services

February 25, 1992

I am Ruth A. Brandwein, Commissioner of Social Services for Suffolk County, New York. I am submitting this testimony in support of legislation which would make health care a right for all our citizens.

In Suffolk County approximately 77,400 individuals, or 5.5 per cent of the population are covered by Medicaid. There are perhaps an equal number of our citizens in need of health insurance who do not meet Medicaid eligibility standards. The Department administers Medicaid, which is a Federal and State mandated program for those who are income eligible.

Despite the large numbers of the population covered by some health insurance, there is growing dissatisfaction with the paperwork involved in seeking reimbursement; consumer and provider confusion over rules and regulations; and a substantial number, estimated to be over thirty million, who are not covered by any health insurance. The system is haphazard. Many people lose benefits when they change jobs and more and more costs for the mentally ill and for the chronically ill elderly are being shifted to Medicaid.

We are not unique in this respect. Our experience in Suffolk County with the problems of financing health care is a microcosm of the care situation across this country. A national health care plan should provide basic hospital services; preventive services including prenatal and well-child care; prescription drugs; and long term in-home and nursing home care. It should deal with the spiraling costs of these services and the duplication in administrative costs associated with the functions of the nation's fifteen hundred private insurance companies. To address this problem, health coverage should be provided by a single payer plan.

Moreover, there is need for federal leadership to clearly define the scope and content of health insurance for the nation. Health insurance is not simply insurance in the conventional sense. It is fundamentally different from other types of insurance because it forms the base for allocating an essential social good and because its existence has a profound effect on the availability, costs and use of medical services. Health care financing is a form of social budgeting. Public policy must recognize it as such in order to better guide the medical care system and to ensure an equitable use of the resources available for this purpose.

I referred earlier to those in our population not covered by health insurance. The need to extend benefits to this group is more urgent than ever, because of the present economic situation and the growing number of those losing their jobs and therefore the health coverage they may have had while employed. Therefore, any national health legislation must provide universal coverage.

I have also indicated that it should cover preventive services. Preventive activities are of sufficient importance in their own right to warrant integration in the mainstream of the nation's health care system and its financing. Preventive services, when specifically defined and when focused on appropriate groups, can be cost effective.

Of the various legislative proposals before the Congress, I support a government sponsored approach. Those proposals which would assist people to purchase private insurance neglect to address fundamental problems of the present system. Moreover, most private plans offer only limited benefits in preventive care and none for chronic care. Those proposals whereby employers either provide insurance to employees or pay taxes to finance an alternate public system are attractive because they would provide universal coverage. However, the cost of health insurance is already an important factor in this country's cost of doing business. Private insurance premiums are increasing at a rate of 15 per cent a year; employer contributions for health insurance now average 11 per cent of payroll.

Replacing private employment-based health insurance with a social insurance program would eliminate labor-management conflicts over health benefits, a major source of workplace strife. Separating coverage from employment would eliminate "job lock" permitting greater labor market flexibility and mobility because workers could change jobs without fear of losing health benefits. Untying coverage from employment and replacing it with tax financing would eliminate disruptions in coverage and changes in plans and physicians whenever an employee changes jobs, becomes unemployed, disabled or retired, or when a dependent becomes divorced or widowed. Separating health eligibility from employment would enable people to join any approved plan in their area, rather than choosing from a few offered by their employer. Finally, eliminating the link of employment and coverage would facilitate universal participation in one financing system. This is the best protection for low-income groups who otherwise would depend on separate public programs as they do today and as they would in other reforms that create a public program only for those not fortunate enough to be covered by an employer who "plays." Only in a universal program, which is available to the total population regardless of income, can lower income workers and the poor avoid political isolation in a program that is vulnerable to the budgetary axe. Services for the poor become poor services. With a strong constituency benefiting from these universal services, quality for all is assured.

Compared with our present system and compared with all "play or pay" proposals in Congress, I support legislation which would improve access to primary and preventive care, control costs, reduce or eliminate patients' out-of-pocket costs, finance health services more equitably, offer enrollees more choice of health plans, remove the burden of administering health benefits

from employers, increase job mobility and reduce administrative costs for physicians, hospitals and most health plans. Of the various proposals, I believe HR 1300, S.144 and HR 650/651 meet these specifications.

689 Windmill Ave
 No. Babylon, N.Y. 11704
 January 21, 1992

Sub-Committee on Human Services
 Rm. 715, O'Neil Bldg.
 U.S. House of Representatives
 Washington, D.C. 20515
 ATTN: John Olinger

Dear Sir:

I'm quite concerned about the state of Health-Care Choices for the Handicapped and disabled. I have a child almost 3 years old who has Down Syndrome who has no major health problems - he does not have a heart abnormality (40% of Down Syndrome babies are born with heart abnormalities). Due to his low muscle tone and mental retardation, he will be considered disabled but it does not mean he will be medically costly. He does receive early intervention - Special education and physical and speech therapy which is paid by our education taxes.

As I've been finding out, health insurance companies refuse to insure all mentally retarded people including Down Syndrome people even if they are healthy. They said it would be prejudice to insure the healthy ones and disclude the sick ones of this group of people. I understand the cost effectiveness of not insuring sick people but to say all mentally retarded people are not insurable even if they are healthy is being prejudice in my opinion. They consider mental retardation, a pre-existing condition like diabetes and heart disease.

My husband and I had health insurance through the company I worked for. Now I am no longer employed and we are covered temporarily under COBRA for 18 months. My husband is self-employed with a 2 person company. The only choice we have after COBRA as I checked into Health Insurance is to take out Empire Blue Cross Blue Shield.

It has open enrollment but the coverage is limited - \$1,000 deductible per family member and the rates are extremely high for this coverage. Blue Cross Blue Shield is requesting a 40% increase for this year. No matter what the rate increase, the whole system of open enrollment maybe in jeopardy if the state legislature does not approve a measure that would prevent commercial insurers from skimming off the best customers. These insurers should not be allowed to disclude a whole group of people just because they are mentally retarded.

If you change jobs, the new company's insurance company will refuse insurance to any member of your family who is mentally retarded or who is disabled and considered a high cost risk in their minds, when in fact many are very healthy people.

As a voter and taxpayer, I think we have a need for some form of socialized medicine that would not discriminate against groups of people and would insure the same health care coverage for the entire population in this country.

Sincerely yours,
Susan J. Collins-Lee



NATIONAL ASSOCIATION OF PUERTO RICAN
HISPANIC SOCIAL WORKERS
P.O. BOX 651 BRENTWOOD, N.Y. 11717

January 14, 1992

STATEMENT ON NATIONAL HEALTH CARE - PRESENTED TO CONGRESSIONAL COMMITTEE AT A TOWN MEETING at Suffolk Community College, Brentwood

My name is Sonia Palacio-Grottola, President of National Association of Puerto Rican/Hispanic Social Workers. I am also an active member of National Committee on Minority Affairs for National Association of Social Workers.

I want to take this opportunity to make a brief statement urging you to back the reform of the nation's health care system by replacing the current 1,500 public and private health insurance programs with a single-payer, publicly administered system.

The Association believes that all Americans and residents of this country should have the assurance of quality health, mental health and long-term care available to them.

We support the proposed "UNIVERSAL HEALTH CARE ACT OF 1991," introduced last March by Rep. Marty Russo which incorporated major portions of the health plan as presented by the National Association of Social Workers.

This plan incorporates the SINGLE-PAYER approach wherein everyone would be covered by the same plan. Barbara White, President of NASW, stated that cost containment and administrative costs savings are key elements of the single-payer approach. She cited numerous benefits to health care providers and businesses during her presentation to the House Ways and Means Committee in Oct 24. The following items would be benefits for the consumers..

For consumers in general, the benefits would be:

- . Universal coverage for comprehensive care, regardless of income or preexisting conditions.
- . Simplicity in using and understanding a single-payer system to obtain care.
- . Flexibility for workers to move from one job to another without losing health care benefits.
- . Freedom in selecting care providers.

For senior-citizen consumers, the benefits would be:

- . Coverage of prescription drugs and long-term care services, two of the highest costs faced by the elderly.
- . Elimination of out-of-pocket payments and cost-sharing.

Seniors For Action

J. 499

Sherman Oaks-Van Nuys Center
5040 Van Nuys Blvd.
Sherman Oaks, CA. 91423
(818) 501-9176
(818) 985-4219
(818) 789-8935

January
19 92

Dear Legislator:

We, SENIORS FOR ACTION, are working very diligently for a National Health Care Program and are very pleased to learn that you and some of your colleagues are endorsing the Russo bill, H.R.1300.

SENIORS FOR ACTION too, will endorse the Russo bill except for the manner of funding. We want a single payer system, based on the Canadian Plan.

The enclosed re-print of the GAO report published in the newspapers in an abbreviated form, on June 4th, 1991, clearly indicates funds can easily be available and at considerable savings over present costs.

It is disgraceful that the United States is one of only two industrialized nations in the world, without a National Health Care Program..... but we can help support the economy of the world, totally disregarding the shameful situation here at home.

It is time our elected legislators had the political courage to recognize and act for the welfare of their constituents... making this a #1 priority in 1992.

Respectfully,

Belle H. Palmer
Belle Palmer
President

bp:lw
enc.

National Health Coalition

LOS ANGELES TIMES
TUESDAY, JUNE 4, 1991

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GAO Report Hails Canada Health System

■ **Congress:** The study says a variation of the government-run program could save money and extend care to all citizens.

From Associated Press

WASHINGTON—The U.S. government could extend health care to all its citizens and still save money by adopting Canada's national system, according to a draft congressional report to be released today.

The General Accounting Office's study of Canada's 20-year-old health-care program concluded that the United States has much to learn from its neighbor's government-run system, which streamlines administrative costs and reduces paperwork for physicians and hospitals.

"If the universal coverage and single-payer features of the Canadian system were applied in the United States, the savings in administrative costs alone would be more than enough to finance insurance coverage for the millions of Americans who are currently uninsured," the report said.

The savings might even be large enough to eliminate deductibles and co-payments insured citizens

now pay, making health care free for everyone, said the GAO, a congressional investigative agency.

But the report said that on this point Americans might not want to replicate the Canadian system. Instead, the United States could combine the best of both systems, such as by continuing to require some cost-sharing for medical care but ensuring timely access to services.

Critics of the Canadian system often point to long waits in that country for some medical procedures and services. Some Canadians travel to U.S. hospitals for medical services so they don't have to wait months.

As the debate over the need for health-care reforms has accelerated in this country, some have focused on the Canadian system as a model for a system that would allow the United States to provide health care for an estimated 35 million uninsured citizens and stem double-digit growth in medical costs.

"The economic rationing of health care under our current system could come to an end" under a Canadian-style system, said Rep. John Conyers Jr. (D-Mich), chairman of the House Government Operations Committee.

"People wouldn't be refused insurance because they have a pre-existing condition such as cancer.

Families wouldn't be impoverished to care for a sick loved one," he said.

Health-care spending in the United States is expected to exceed \$550 billion this year, accounting for about 12% of the gross national product. With no changes in the system, it is heading for a 15% share of the GNP by the turn of the century, experts predict.

The Canadian system provides health care for all the country's citizens, with no deductibles or co-payments, at a cost that is less than what the United States pays for a system that excludes millions of people and charges out-of-pocket costs for those who have insurance.

In 1989, per-capita health spending in the United States was \$2,196, compared with \$1,570 in Canada.

Health indicators also favor Canada: average life expectancy of Canadian men is 73.1 years, while it is 71.3 years for American men, and Canada's infant mortality rate is lower.

Adopting a Canadian-style system would save about \$67 billion in administrative costs, the GAO estimated. Universal insurance coverage without cost-sharing would result in about \$64 billion in added costs, for a net savings of \$3 billion, the report said.

**For information to join
the NATIONAL HEALTH COALITION write**
Sherman Oaks-Van Nuys Center,
5040 Van Nuys Blvd. Sherman Oaks,
California, 91423 or call (818)
902-2146 or (818) 789-8935

The National Health Coalition is sponsored by the Federation of Retired AFL-CIO Members and Seniors for Action - a coalition of consumer, civic union and senior regional groups reflecting the views of grass roots America

LONG ISLAND RESPONDS TO AMERICA'S HEALTH CARE CRISIS

SAGTIKOS THEATRE, CROOKED HILL ROAD, SUFFOLK COMMUNITY COLLEGE, BRENTWOOD,
NEW YORK --- JANUARY 14, 1992

My name is John E. McDonald. I am the Chairman of the Suffolk County Senior Citizens Advisory Board and also the Chairman of the Suffolk County Senior Citizens Health Task Force.

I am very interested and concerned about the lack of a National Health Care Plan and have been trying to determine which approach is best for our country.

The first time I heard about Congressman Russo's Universal Health Care Act of 1991 (HR-1300) was in the April 1991 issue of the Public Citizen Health Research Group - Health Letter. I had been interested in the Canadian Health Care System before then and had procured a copy of the regulations as practiced in the Province of Alberta, Canada. My father was born in the Province of Quebec in a family of 13 children. I have been in contact with many of their descendants over the years and most of them still live in Canada. The majority of them speak very highly of their Health Care System. A small number don't like certain things about their particular system but in general they like it especially when I tell them how much we pay for Health Care here in the United States.

On June 19, 1991 I attended one of Governor Cuomo's Town Meetings on Universal Health Care at Melville, Huntington. Four different Health Plans were discussed at that meeting. To me, it seemed as though these systems would be very costly to administer as the sources of financing for all of them was employer based.

That feeling was reinforced when I read an article on the Administrative Cost of Health Insurance in the June 1991 issue of the Health Letter which as I mentioned before is published by the Public Citizen Health Research Group. The article on the Administrative Cost of Health Insurance which was in the May 2, 1991 issue of the New England Journal of Medicine was written by Drs. Steffie Woolhandler and David U. Himmelstein of Harvard University. One of the statements in the article said that the present rate of growth, administrative costs of our present will consume one third of the health budget in twelve years and one half by the year 2020. The Health Letter article goes on to compare the administrative

-2-

costs of the Canadian system with our present system and concludes that money now wasted on administrative overhead could be spent on patient care, if the nation or individual states adopted a single payer system like Canada's.

To reinforce this point there is an article on the back page of the June 1991 Health Letter concerning the A.A.R.P.'s administration of their health care insurer - Prudential. In that article a statement was made - "During the last four years for which A.A.R.P. has published such financial data (1986-1989), it has received a total of \$348 million - \$273 million in group insurance administrative allowances from Prudential for the group health insurance it helps Prudential to sell to A.A.R.P. members and \$75 million in premium interest on insurance premiums collected from A.A.R.P. members, but has not yet remitted to Prudential. The \$348 million represents more than one third - 34.8 percent - of A.A.R.P. operating revenues during those four years."

The December 1991 issue of the A.A.R.P. Bulletin has an article on page three by Executive Director Horace B. Deets in which one of the paragraphs states - "Indeed we will gladly give up our group health insurance program in exchange for a health care system that includes universal access to quality acute and long-term care, real cost containment and a way to pay for it all that is fair and broad based."

On June 27th I attended the Forum on the Older Americans Act held by the New York State Office for the Aging and spoke about the Health Letter and its articles about national health care. It was well received by the N.Y. Office for the Aging panel and also by the audience.

On July 2nd I attended the meeting at the Student Center of the N.Y. Institute of Technology's Central Islip Campus which Congressmen Russo and Downey moderated. My feelings about the Universal Health Care Act of 1991 -HR-1300 was reinforced by their answers to the two lines of attendants' questions.

Congressman Mrazek held a meeting at the Pall Conference Center of the Woolworth Mansion on July 29th which was attended by members of his Health Advisory Panel. Thirteen different Health Care Bills and two more proposed bills, which had not yet been introduced, were discussed by the panel. Shortly after the meeting I wrote a letter to him in which I indicated my leanings toward the Russo Bill (HR-1300).

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On September 10th the Suffolk County Senior Citizens Health Task Force, which is made up of Seniors and professionals who are with organizations serving Seniors in the health field held a meeting on National Health Insurance. There are 160 people on the mailing list of the Task Force and we usually have 35 to 40 at the meeting. The extensive minutes are sent to all members afterwards.

Ms Elisabeth Acheson, Chair of the League of Women Voters Committee on Health Care Financing and member of the Suffolk Coalition for a National Health Plan was the speaker for the day. She had a list of "Principles for Evaluation of Legislation" which was distributed to all those present. She seemed to favor in general the Russo bill (HR-1300), although she did have some criticisms.

I think, in general, I favor the Russo Bill (HR-1300) because a single payor system is essential, but I do believe there are some provisions which should be reviewed.

Thank you,

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